Connecticut SIM: Creating a Culture of Value

CT Behavioral Health Partnership Oversight Council

October 15, 2015

Agenda

1. What is the State Innovation Model Initiative?
2. What are the components of CT's SIM?
3. What problems are we trying to address?
4. What care delivery reforms are we promoting?
5. Value-based Payment Reform
6. Value-based Insurance Design
7. Health Enhancement Communities
8. Evaluation

Appendix

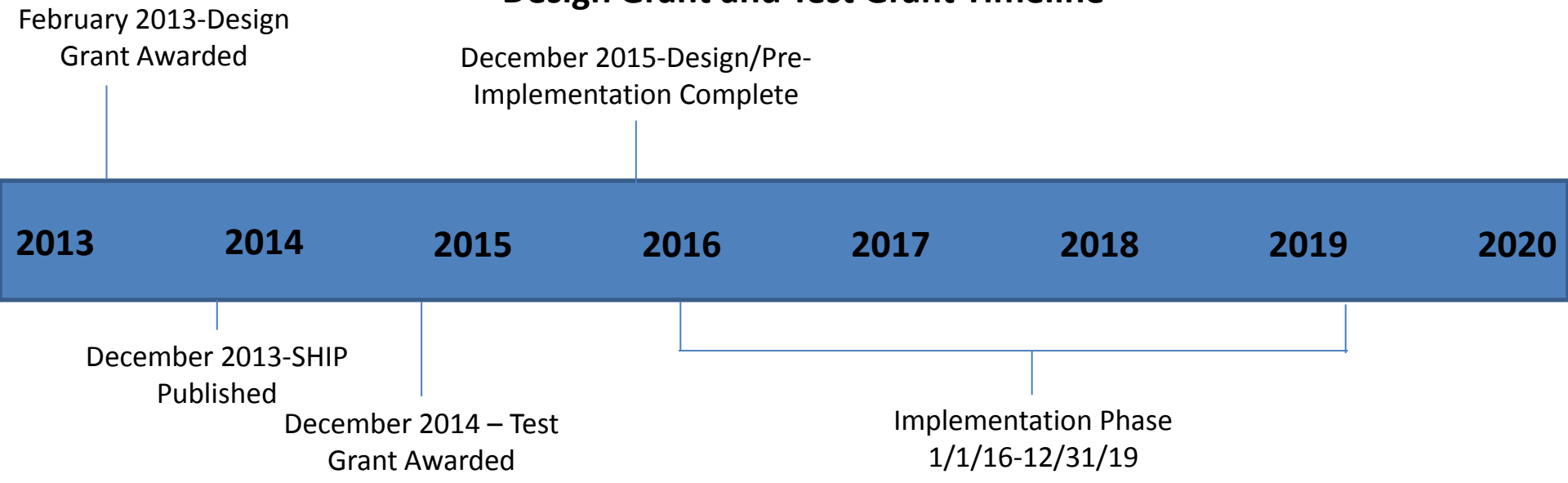
What is a State Innovation Model Grant?

SIM grants are awarded by the federal government through the ***Center for Medicaid and Medicare Services (CMS) Innovation center***. Grants are awarded to states that have demonstrated a commitment to developing and implementing multi-payer health care payment and service delivery models that will:

1. Improve health system performance
2. Increase quality of care
3. Decrease Costs

There are two types of grants awarded; a grant to design an innovation model and a grant to test an innovation model. Connecticut and New York were awarded design grants in April 2014 and test grants in December 2014 which will be implemented over the next five years.

Design Grant and Test Grant Timeline



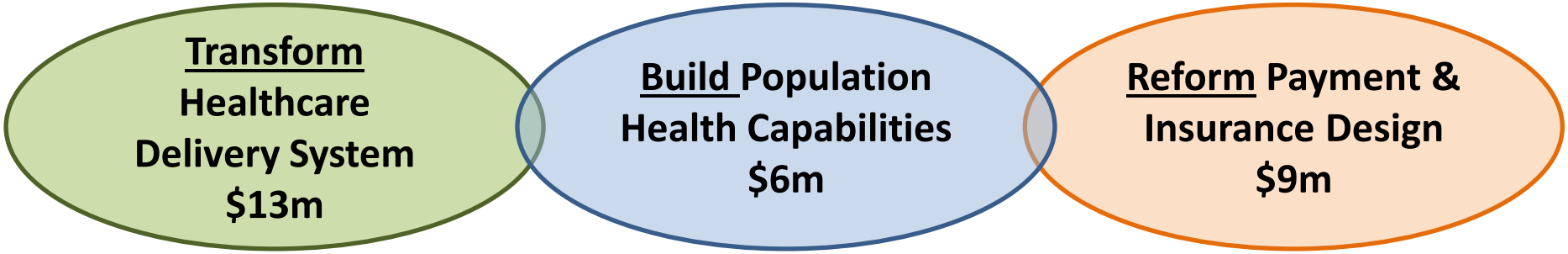
Vision

Establish a whole-person-centered healthcare system that:

- improves population health;
- eliminates health inequities;
- ensures superior access, quality, and care experience;
- empowers individuals to actively participate in their healthcare; and
- improves affordability by reducing healthcare costs

Our Journey from Current to Future: Components

CT SIM Component Areas of Activity



Transform the healthcare delivery system to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

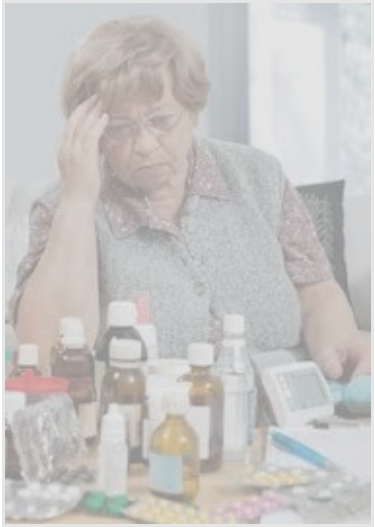
Build population health capabilities that reorient the healthcare toward a focus on the wellness of the whole person and of the community

Reform payment & insurance design to incent value over volume, engage consumers, and drive investment in community wellness.

Engage Connecticut's consumers throughout	**$376k**
Invest in enabling health IT infrastructure	**$10.7m**
Evaluate the results, learn, and adjust	**$2.7m**

Healthcare today – 1.0

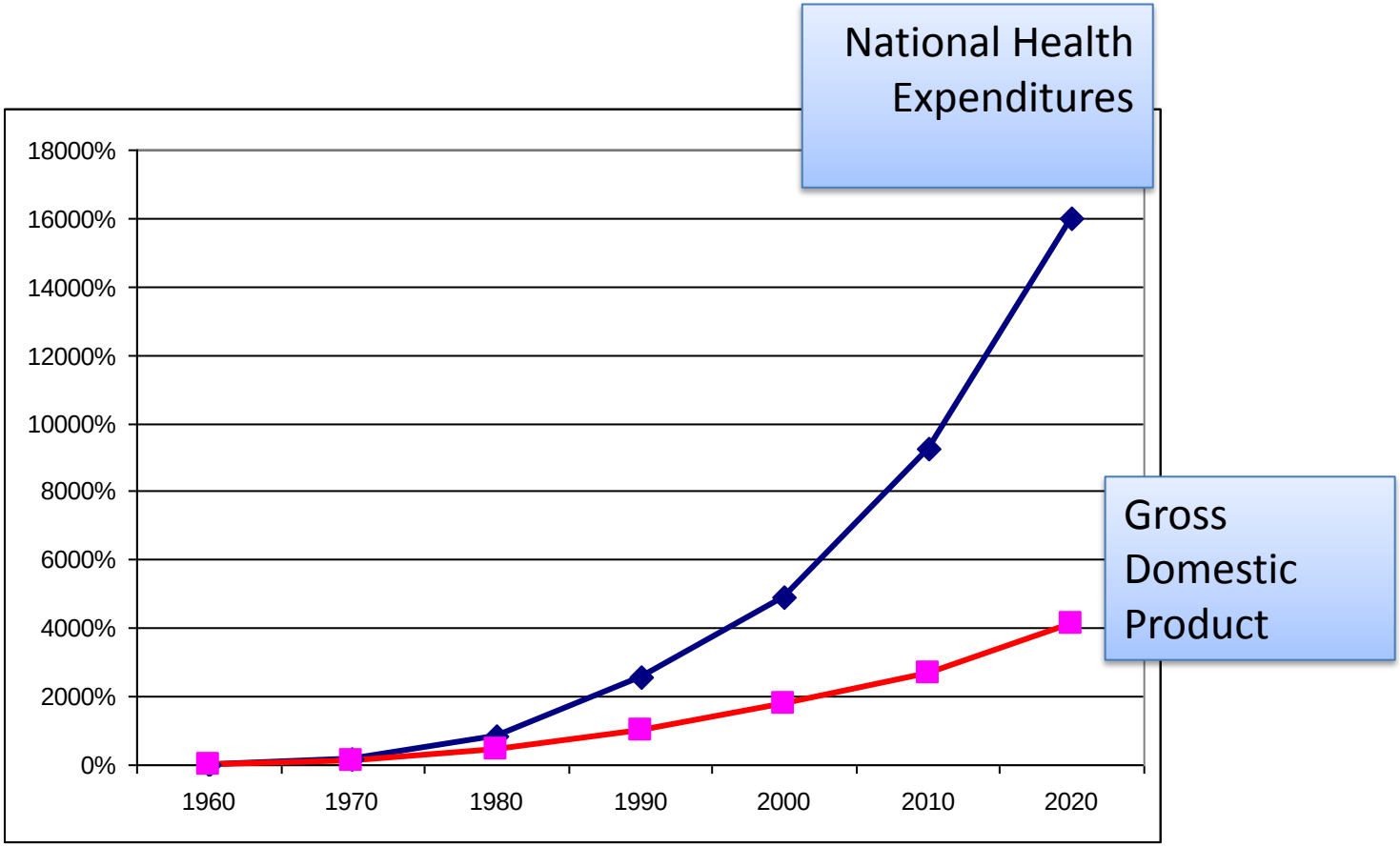
Connecticut's Current Health System: "As Is"



Fee For Service Healthcare 1.0

- **Limited accountability**
- **Poorly coordinated**
- **Pays for quantity without regard to quality**
- **Uneven quality and health inequities**
- **Limited data infrastructure**
- **Unsustainable growth in costs**

Healthcare Spending has Outpaced Economic Growth

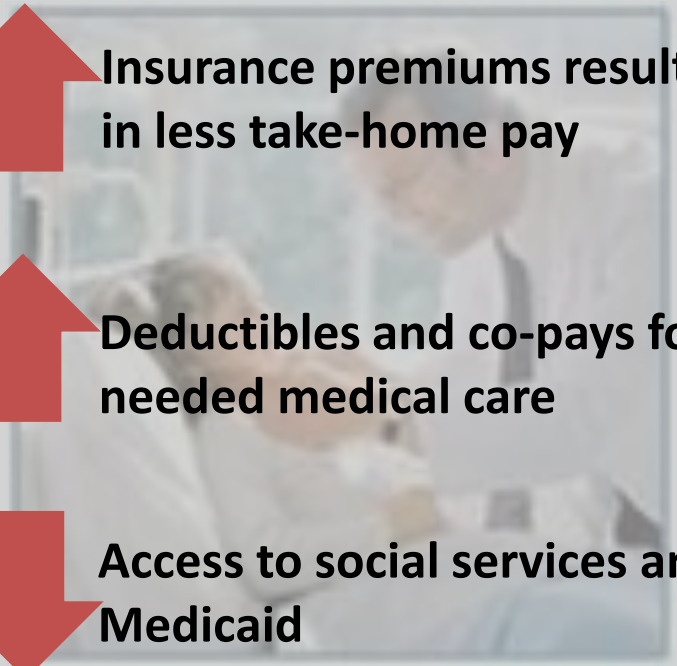


Source: CMS, National Health Expenditure Data

Escalating costs mean…

….patients will experience

- ↑ Insurance premiums resulting in less take-home pay
- ↑ Deductibles and co-pays for needed medical care
- ↓ Access to social services and Medicaid



….communities will experience

- ↓ Money for programs that support housing, education, the environment, and community development

Escalating costs mean…

….the **business community** will experience

US = Lowest Ranking for Safety, Coordination, Efficiency, Health

Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

Commonwealth Fund: http://www.commonwealthfund.org/publications/press-releases/2010/jun/us-ranks-last-among-seven-countries

How about Connecticut?

Connecticut Healthcare Costs

Connecticut *- healthcare spending = More than $30 billion,* ***fourth highest of all states*** *for healthcare spending per capita*

CMS (2011) Health Spending by State of Residence, 1991-2009.
http://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Connecticut: Uneven Quality of Care

Rising rate of Emergency Department utilization

Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	195	183	129	40

CT ranking out of 50 states

High Hospital Readmissions

Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	52.0	45	26	36

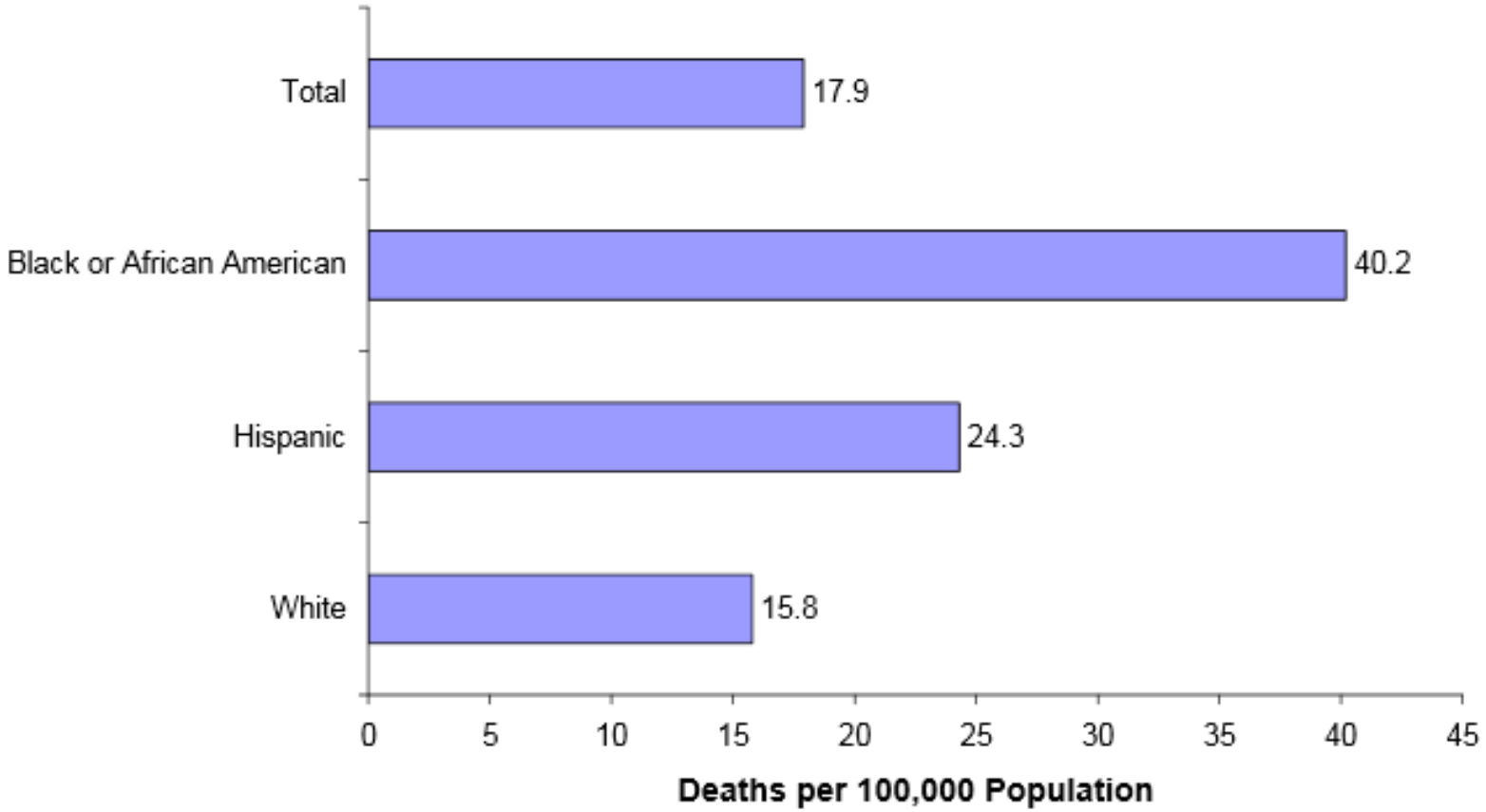
CT ranks 36th out of 50 states

D.C. Radley, D. McCarthy, J.A. Lippa, S.L. Hayes, and C. Schoen, Results from a Scorecard on State Health System Performance, 2014, The Commonwealth Fund, April 2014.

Health disparities persist in Connecticut

Diabetes Death Rates - Race/Ethnicity

Figure 7. Age-adjusted Death Rates for Diabetes, Connecticut Residents, by Race or Ethnicity, 2000–2004



Source: DPH 2008b, 2008v.

Health disparities persist in Connecticut

Health disparities devastate individuals, families and communities, and are *costly*:

- **From 2003-2006 there were $229.4 billion in direct medical costs from minority disparities**
  - **$57.35 billion/year**

- **30.6% of direct costs for African Americans, Asians & Hispanics were due to disparities**

- **The cost of the disparity for the Black population in Connecticut is between $550 million - $650 million a year**

Source: LaVeist, Gaskin & Richard (2009). The Economic Burden of Health Inequalities in the US. The Joint Center for Political & Economic Studies. As reported by DPH

Stages of Transformation

Stages of Transformation

Connecticut's Current Health System: "As Is"

Our Vision for the Future: "To Be"

Fee for Service 1.0

Limited accountability

Pays for quantity without regard to quality

Lack of transparency

Unnecessary or avoidable care

Limited data infrastructure

Health inequities

Unsustainable growth in costs

Accountable Care 2.0

Accountable for patient population

Rewards
- better healthcare outcomes
- preventive care processes
- lower cost of healthcare

Competition on healthcare outcomes, experience & cost

Coordination of care across the medical neighborhood

Community integration to address social & environmental factors that affect outcomes

Health Enhancement Communities 3.0

Accountable for all community members

Rewards
- prevention outcomes
- lower cost of healthcare & the cost of poor health

Cooperation to reduce risk and improve health

Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities

Community initiatives to address social-demographic factors that affect health

Getting to…

Accountable Care 2.0

Targeted Initiatives

Statewide Initiatives

Model Test Hypothesis for SIM Targeted Initiatives

High percentage of patients in value-based payment arrangements

MQISSP
Medicare SSP
Commercial SSP

+

+

Resources to develop advanced primary care and organization-wide capabilities

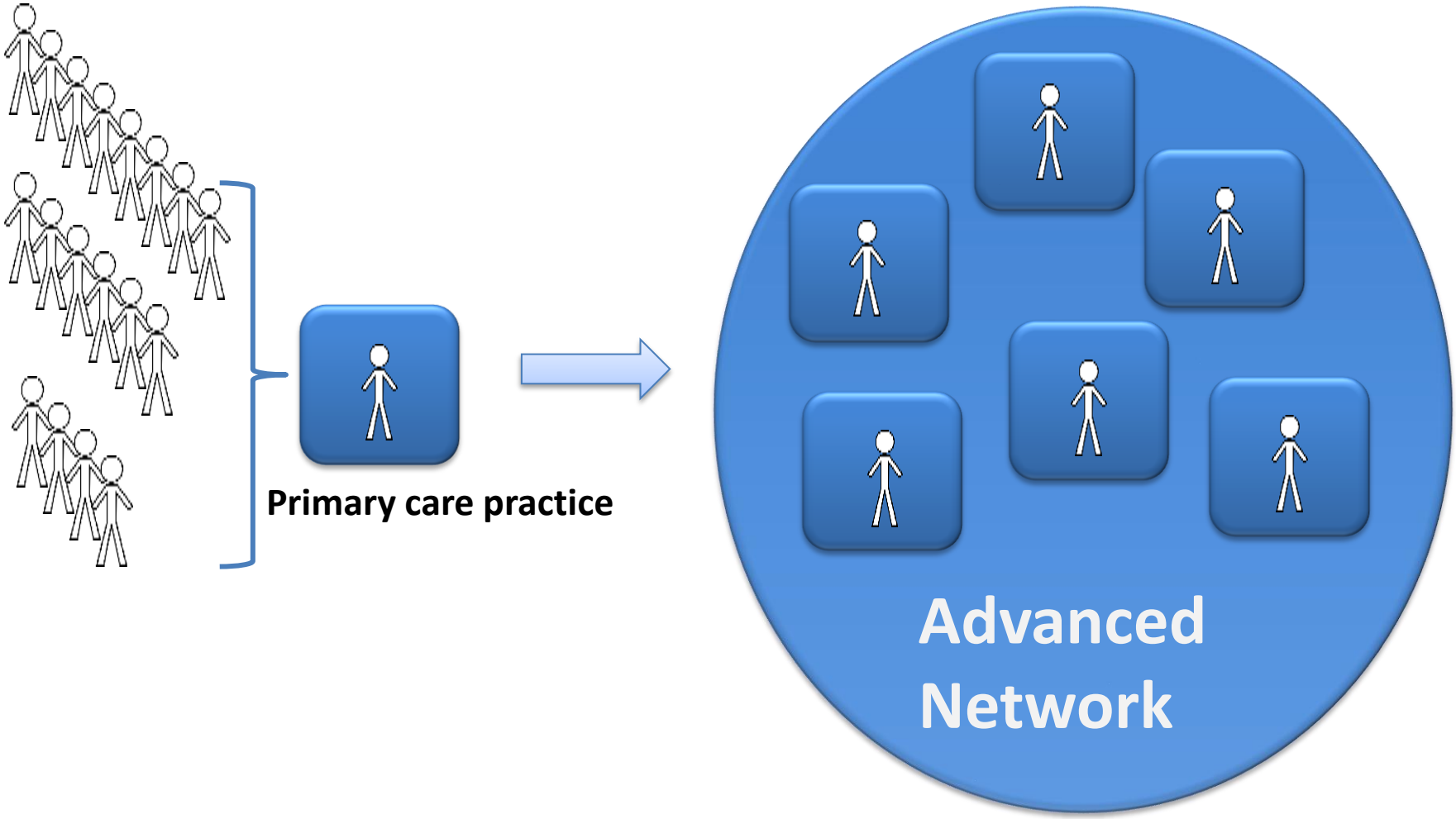
- Advanced Medical Home Program
&
- Community & Clinical Integration Program (CCIP)

=

Accelerate improvement on population health goals of better quality and affordability

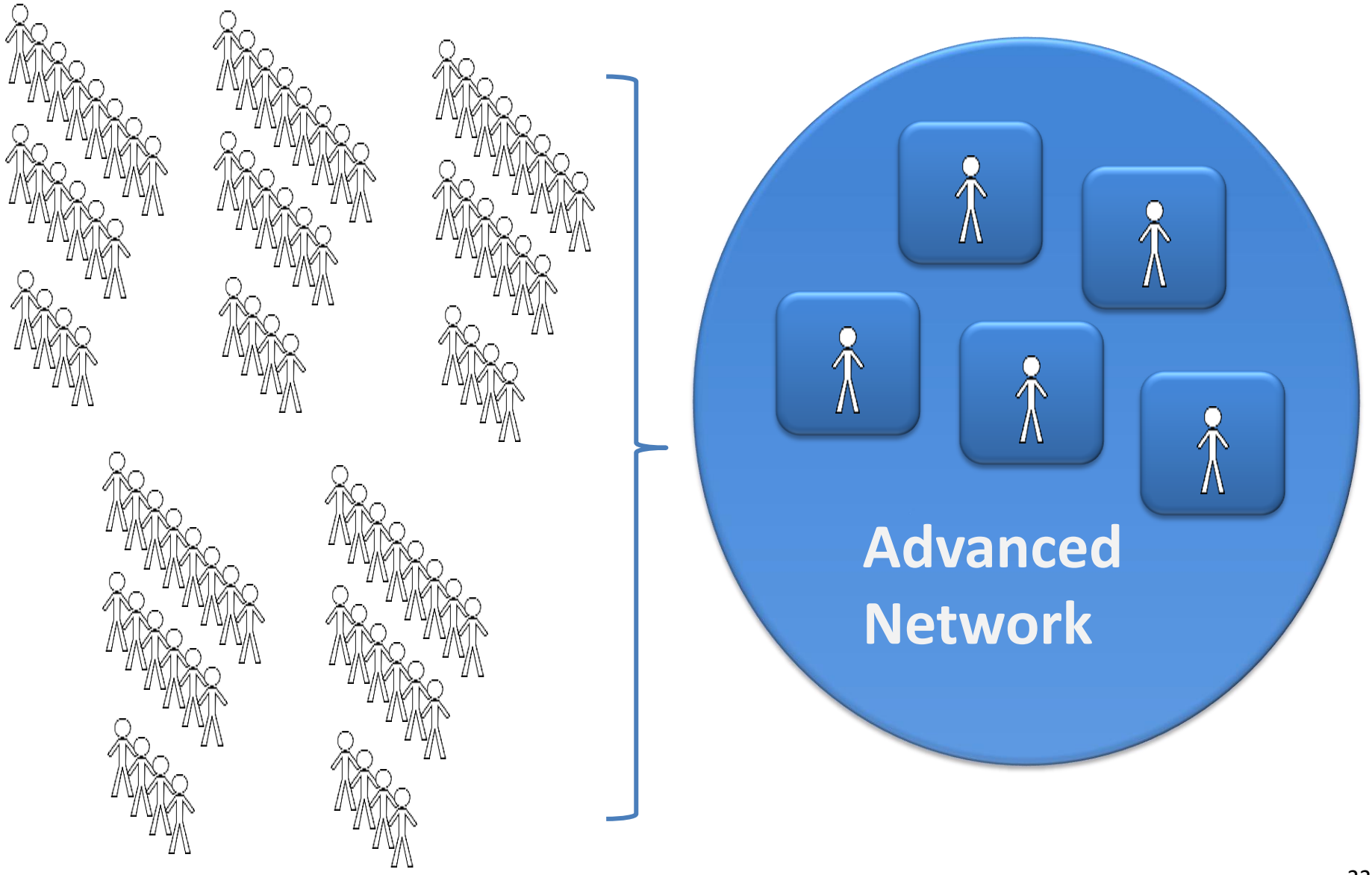
MQISSP is the Medicaid Quality Improvement and Shared Savings Program

Primary care partnerships for accountability

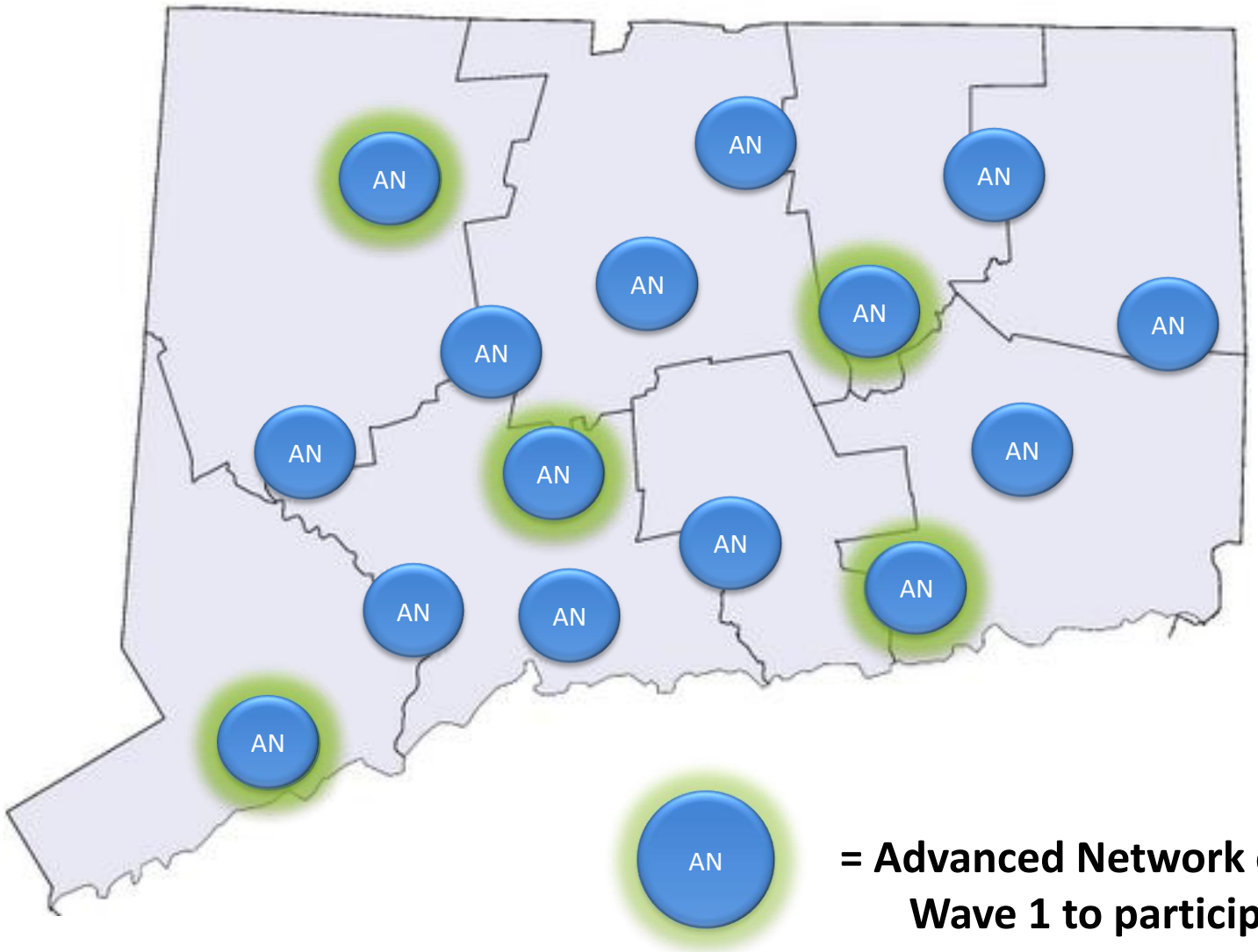


Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer

Accountability for quality and total cost

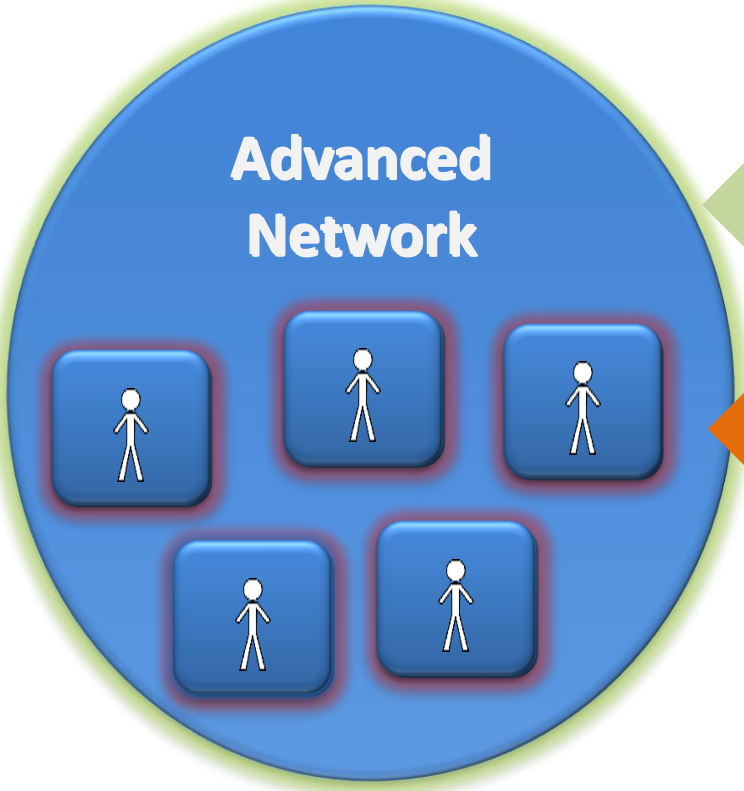


Connecticut has many Advanced Networks



= Advanced Network chosen in Wave 1 to participate in Medicaid Quality Improvement & Shared Savings Program (MQISSP)

Resources aligned to support transformation



Community & Clinical Integration Program (CCIP)

Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program

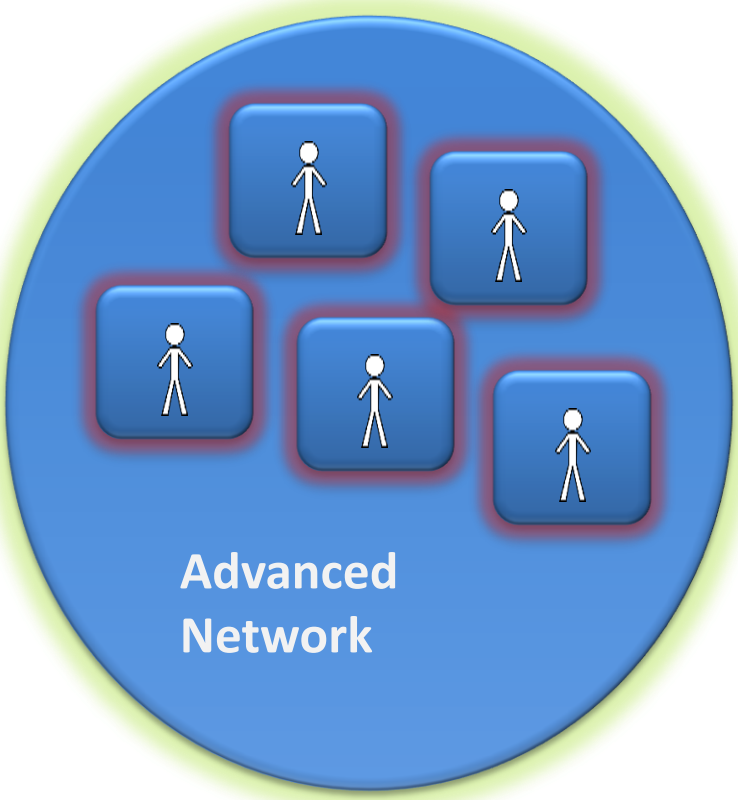
Support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for <u>all</u> populations
Using population health strategies

Improving capabilities of Advanced Networks

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:



Supporting Individuals with Complex Needs

Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Analyze gaps & implement custom intervention ✚ **CHW & culturally tuned materials**

Integrating Behavioral Health

Network wide screening, assessment, treatment/referral, coordination, & follow-up

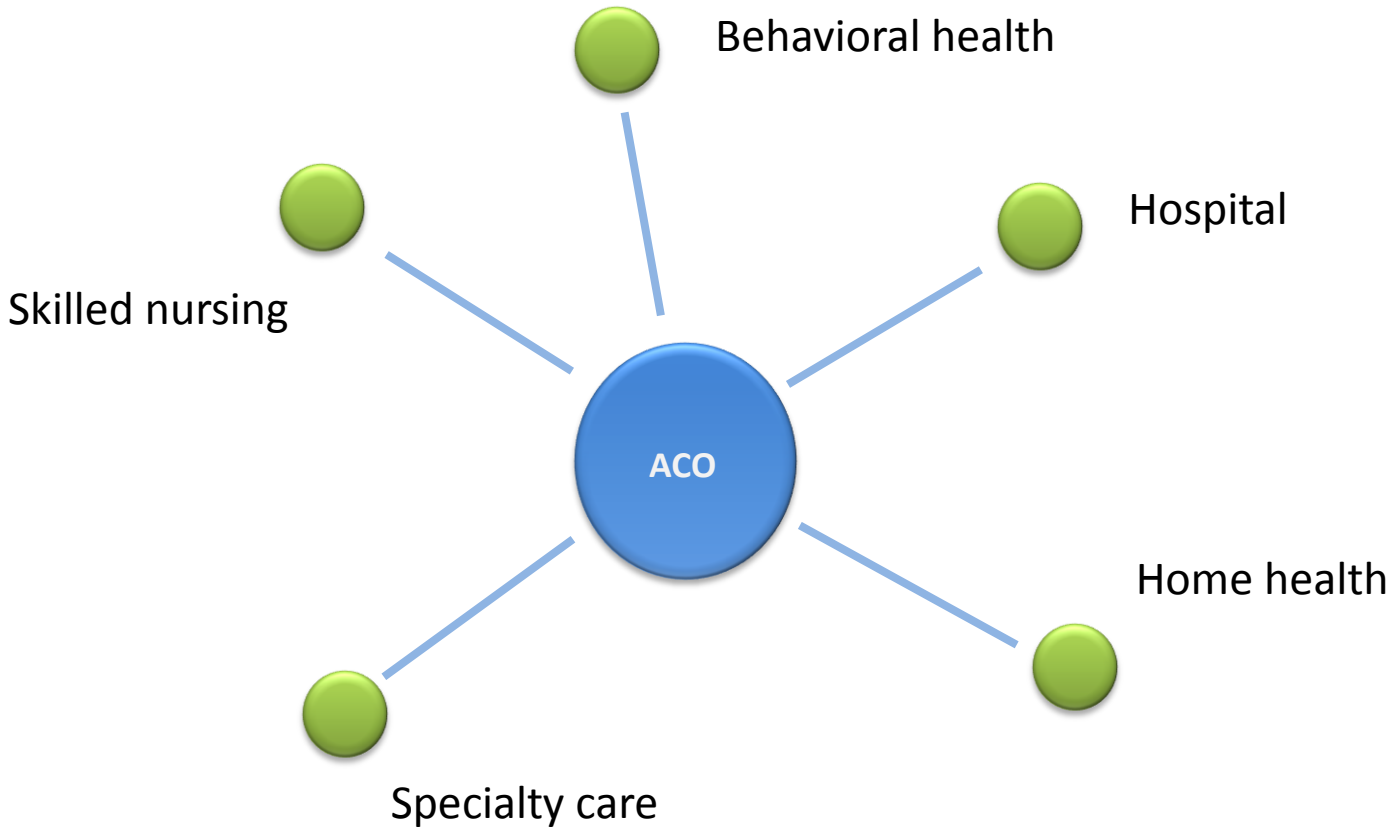
Community Health Collaboratives

Comprehensive Medication Management

E-Consults

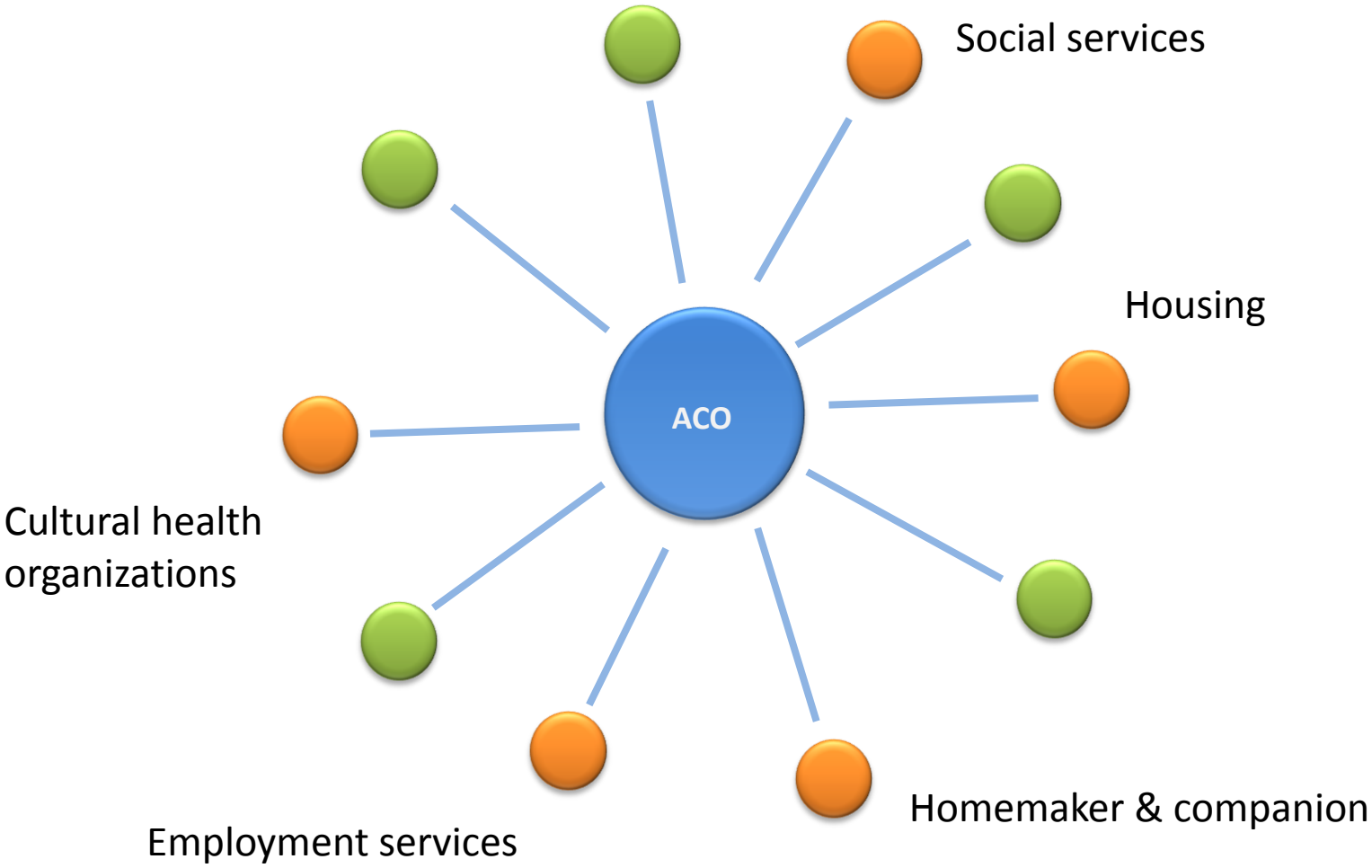
Oral health

New capabilities will support….



…clinical integration and communication across the medical neighborhood

New capabilities will also support…

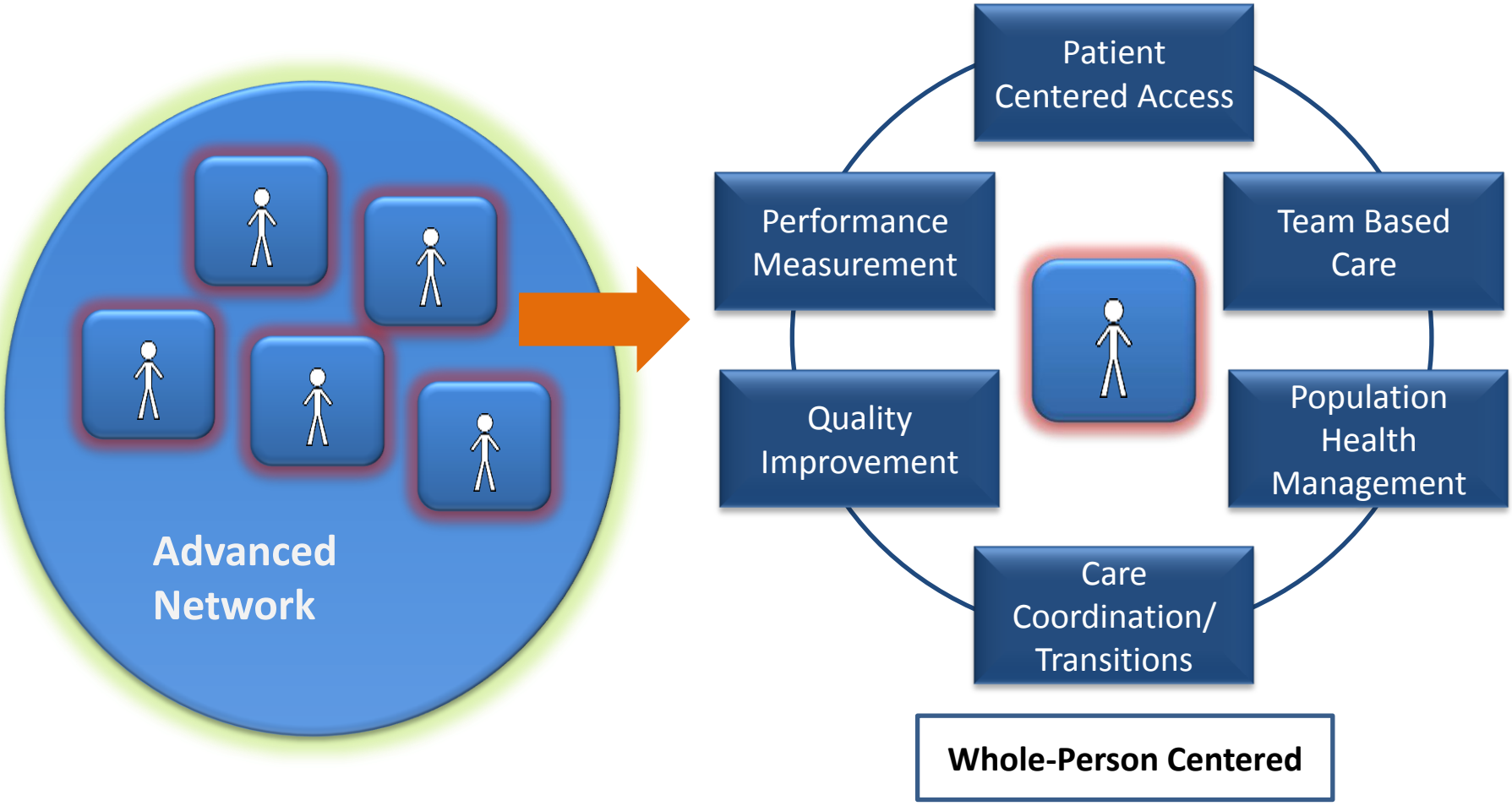


…coordination and integration with key community partners

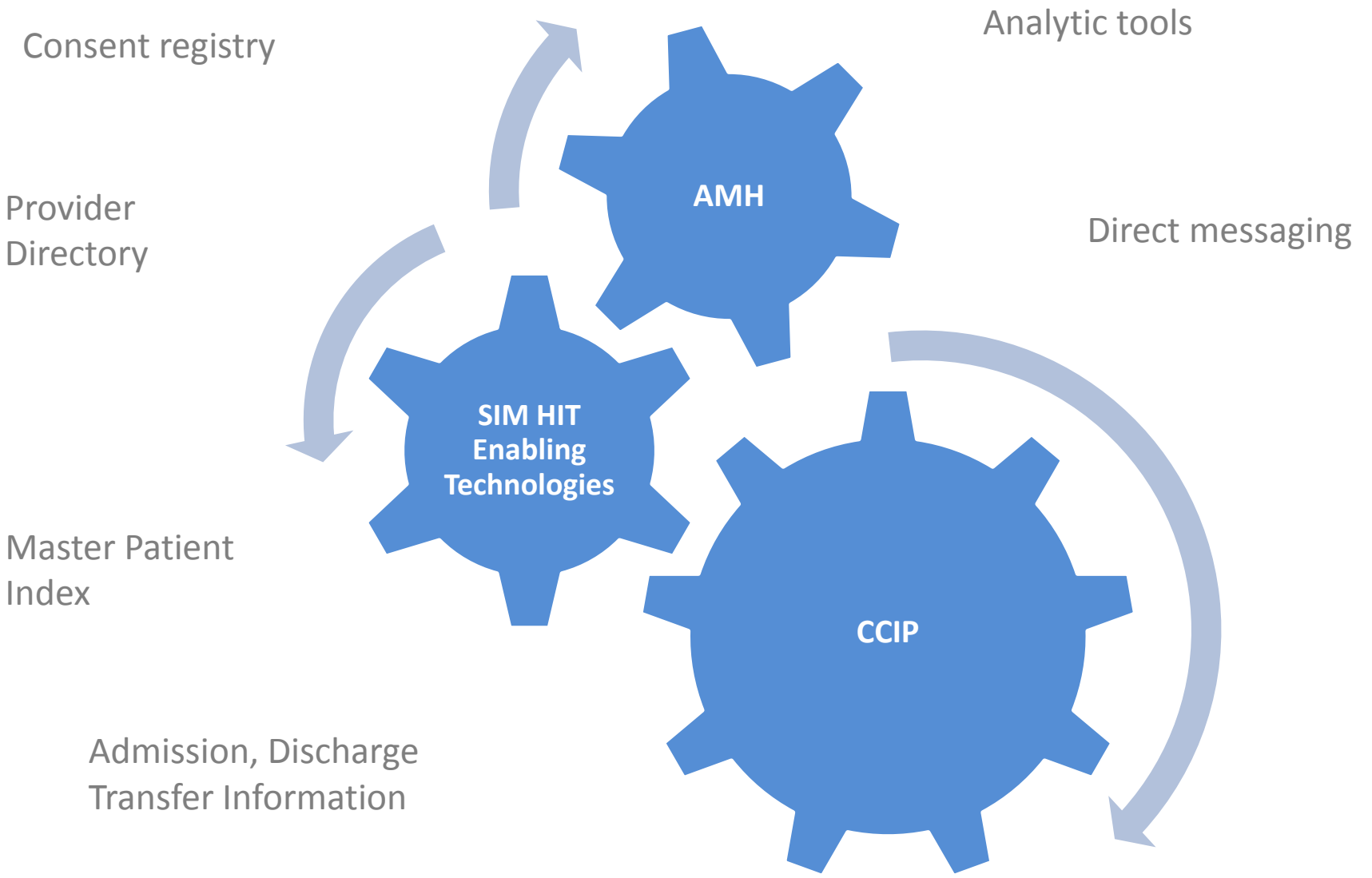
Improving capabilities of practices in Advanced Networks

Advanced Medical Home Program

Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more



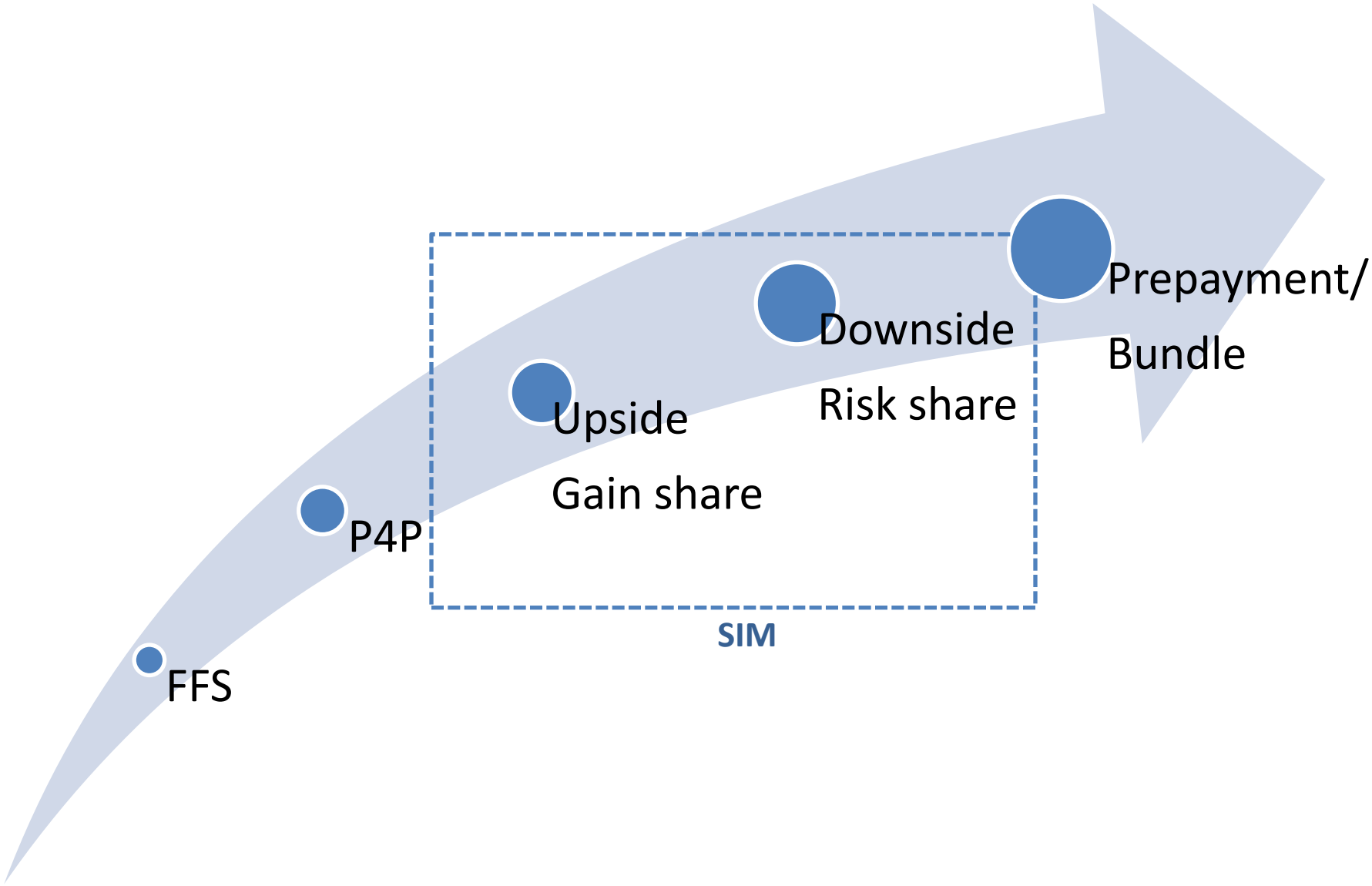
Using HIT to enable new Advanced Network capabilities



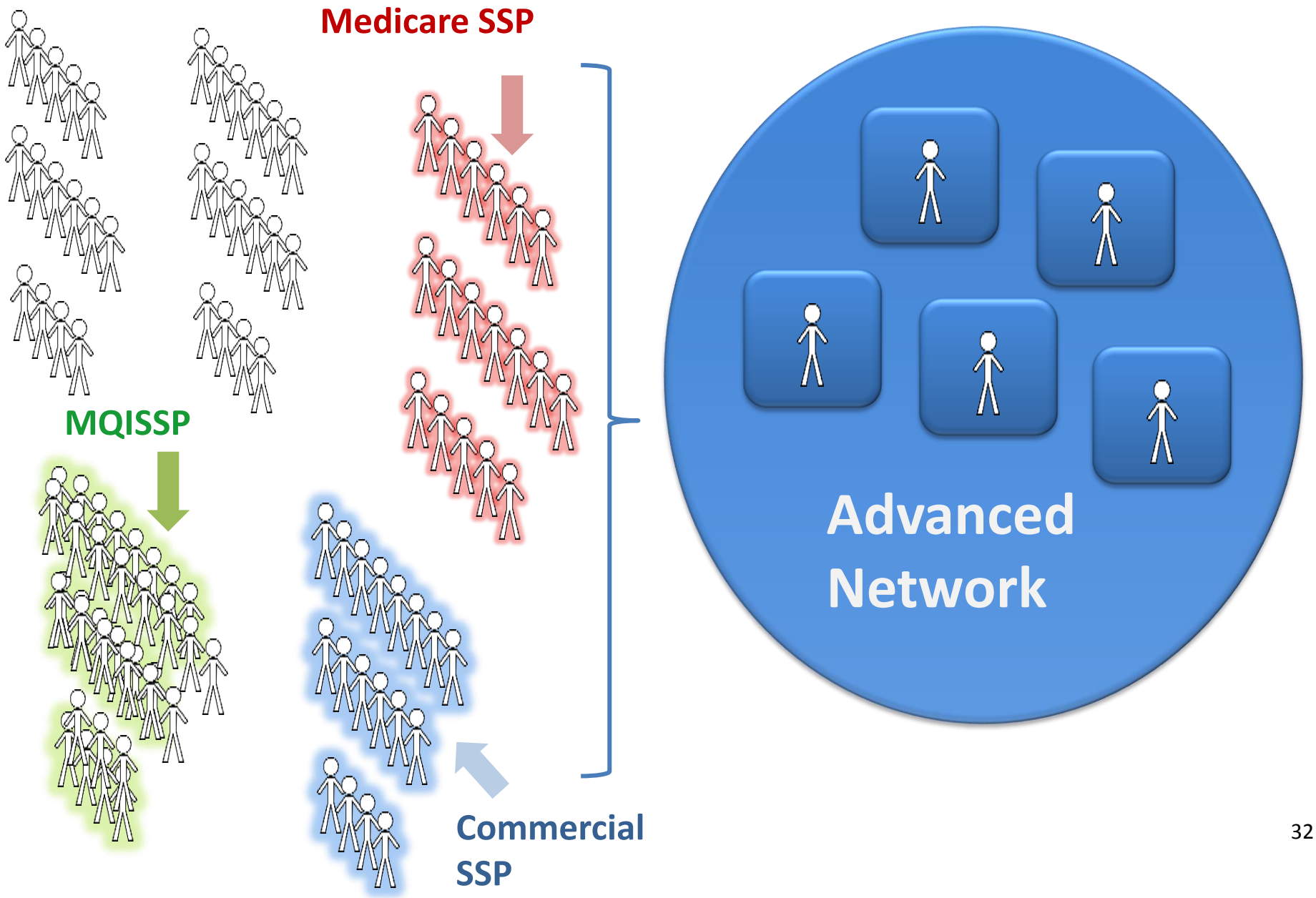
Value Based Payment

$$\text{Value} = \frac{\text{Quality \& Care Experience}}{\text{Total Cost of Care}}$$

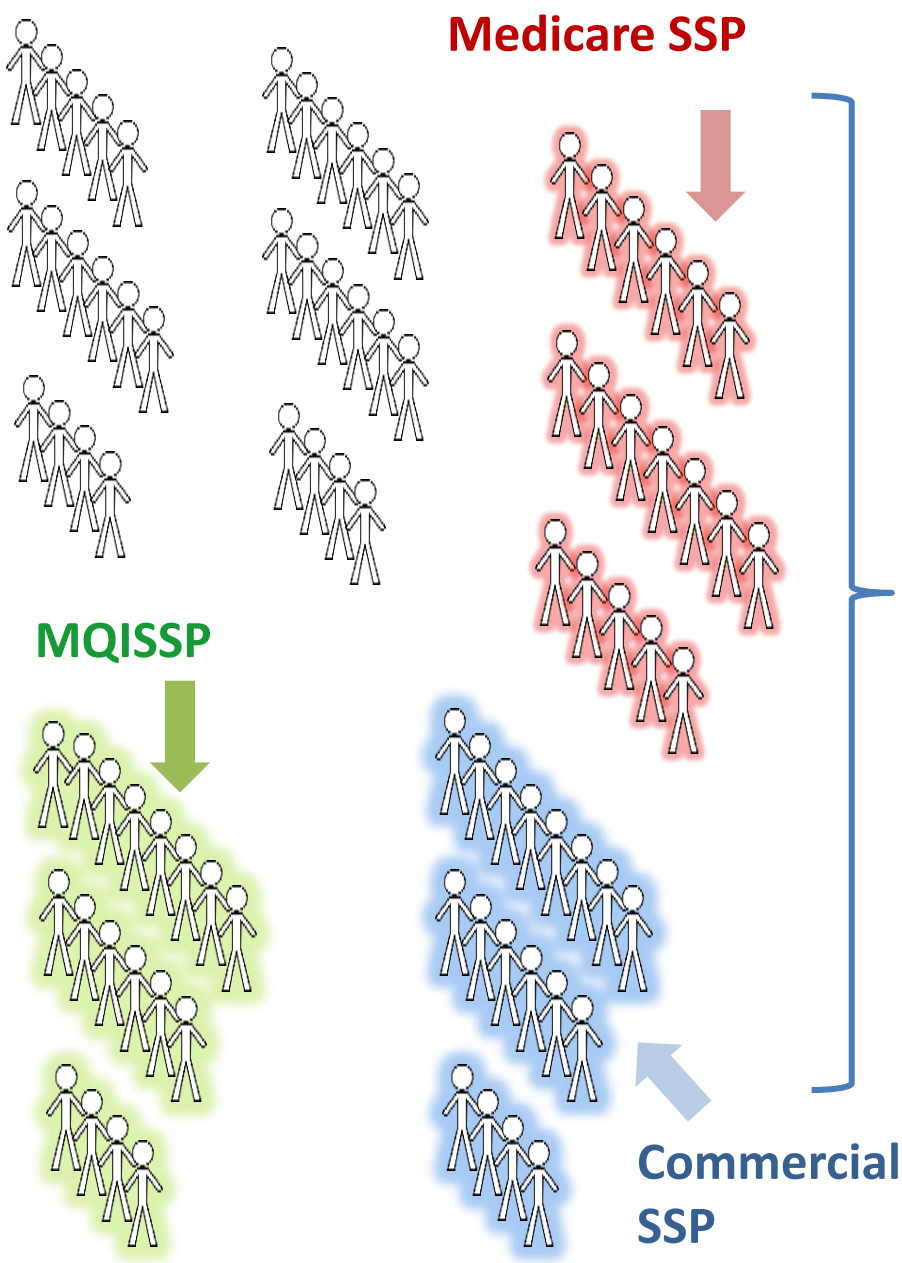
Expanding the reach of Value Based Payment

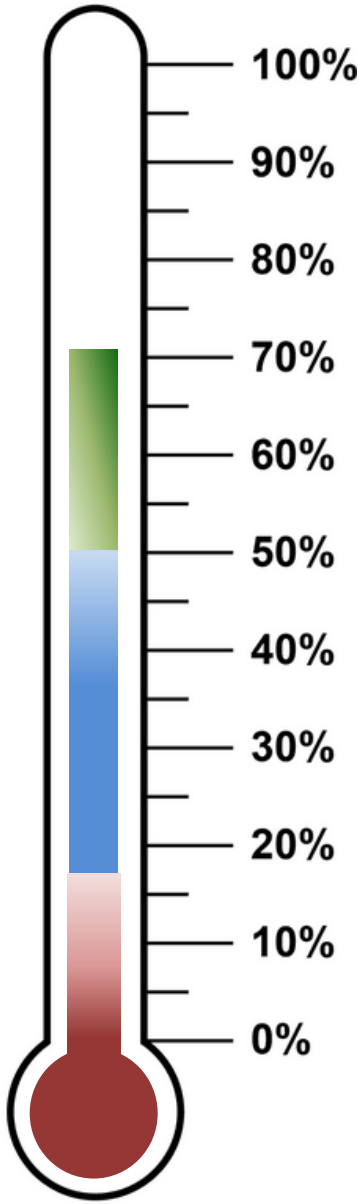


Expanding the reach of Value-Based Payment



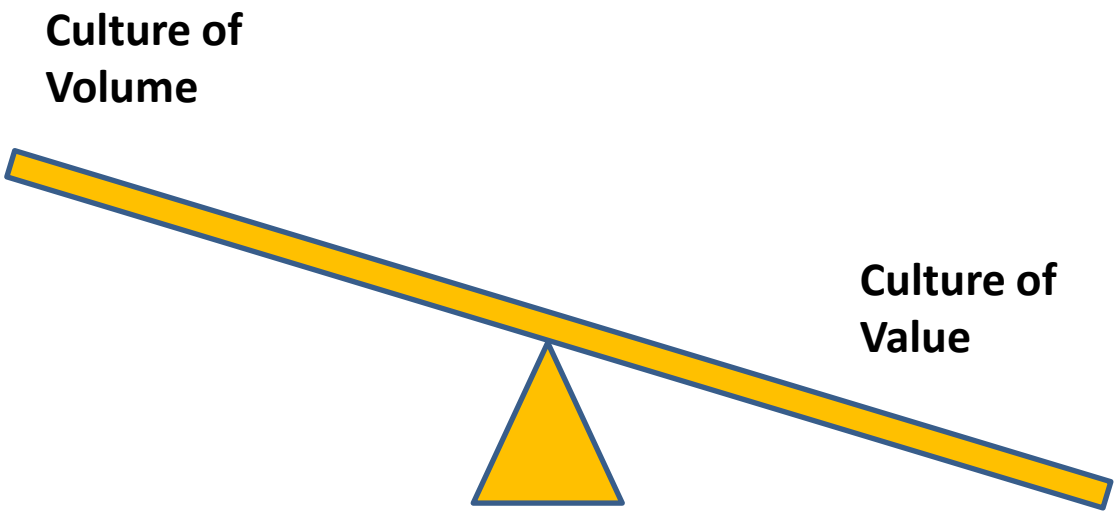
Reaching the tipping point

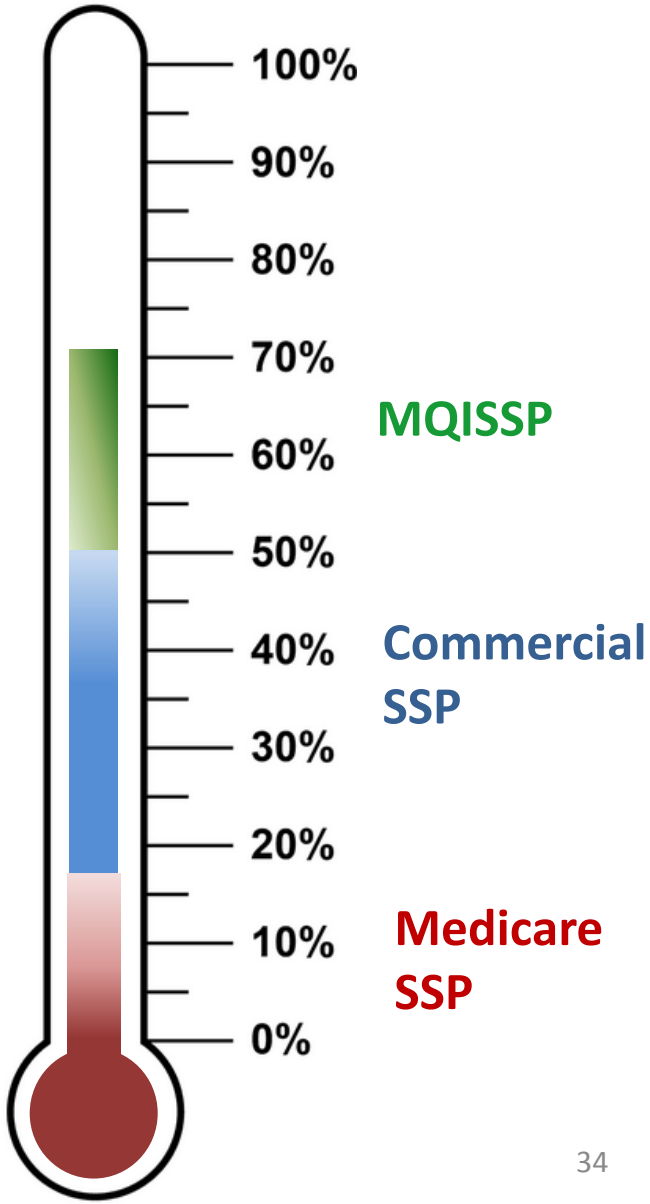




% of consumers in an Advanced Network in value-based payment arrangement

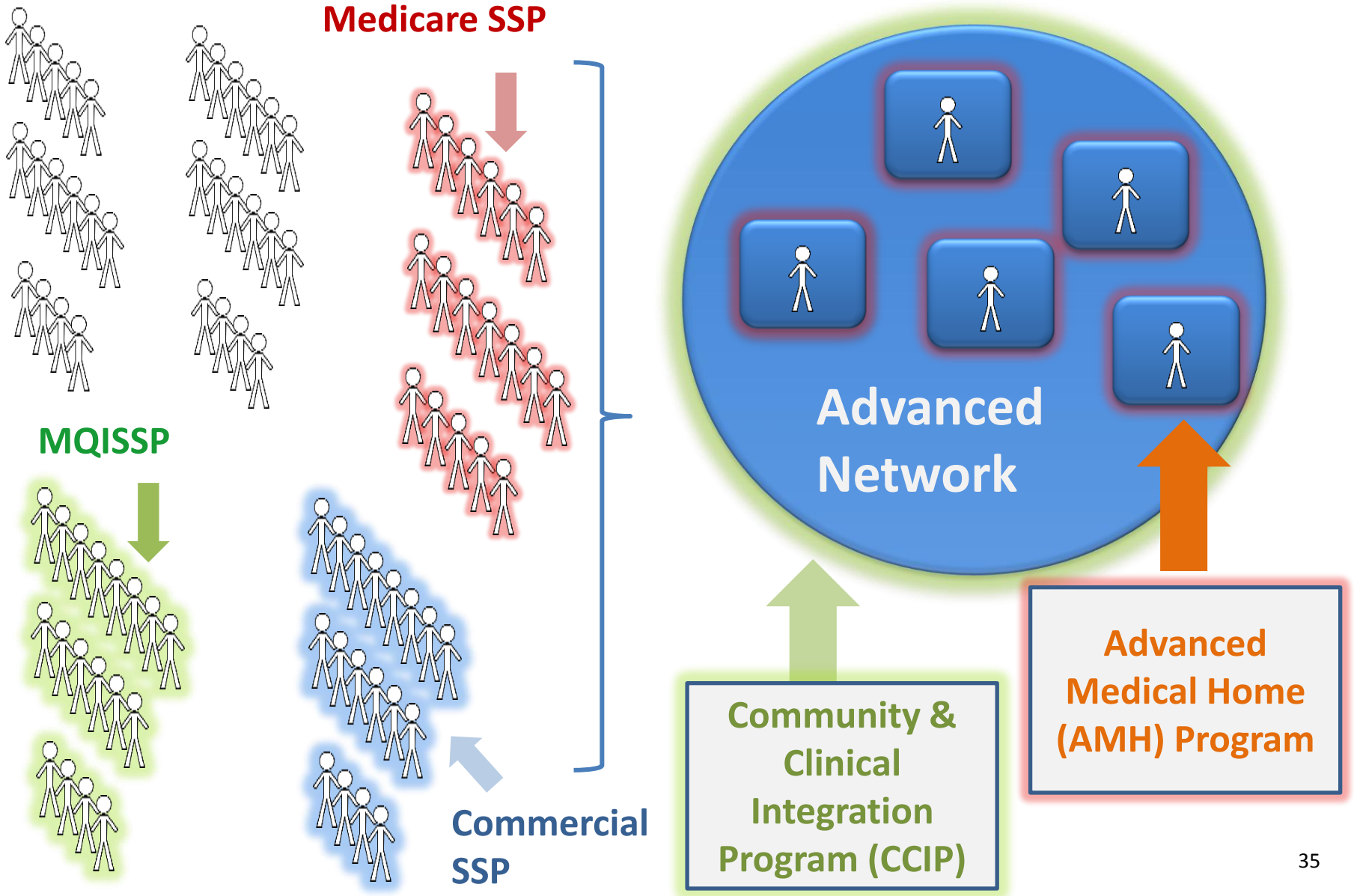
Reaching the tipping point





% of consumers in an Advanced Network in value-based payment arrangement

Putting it all together



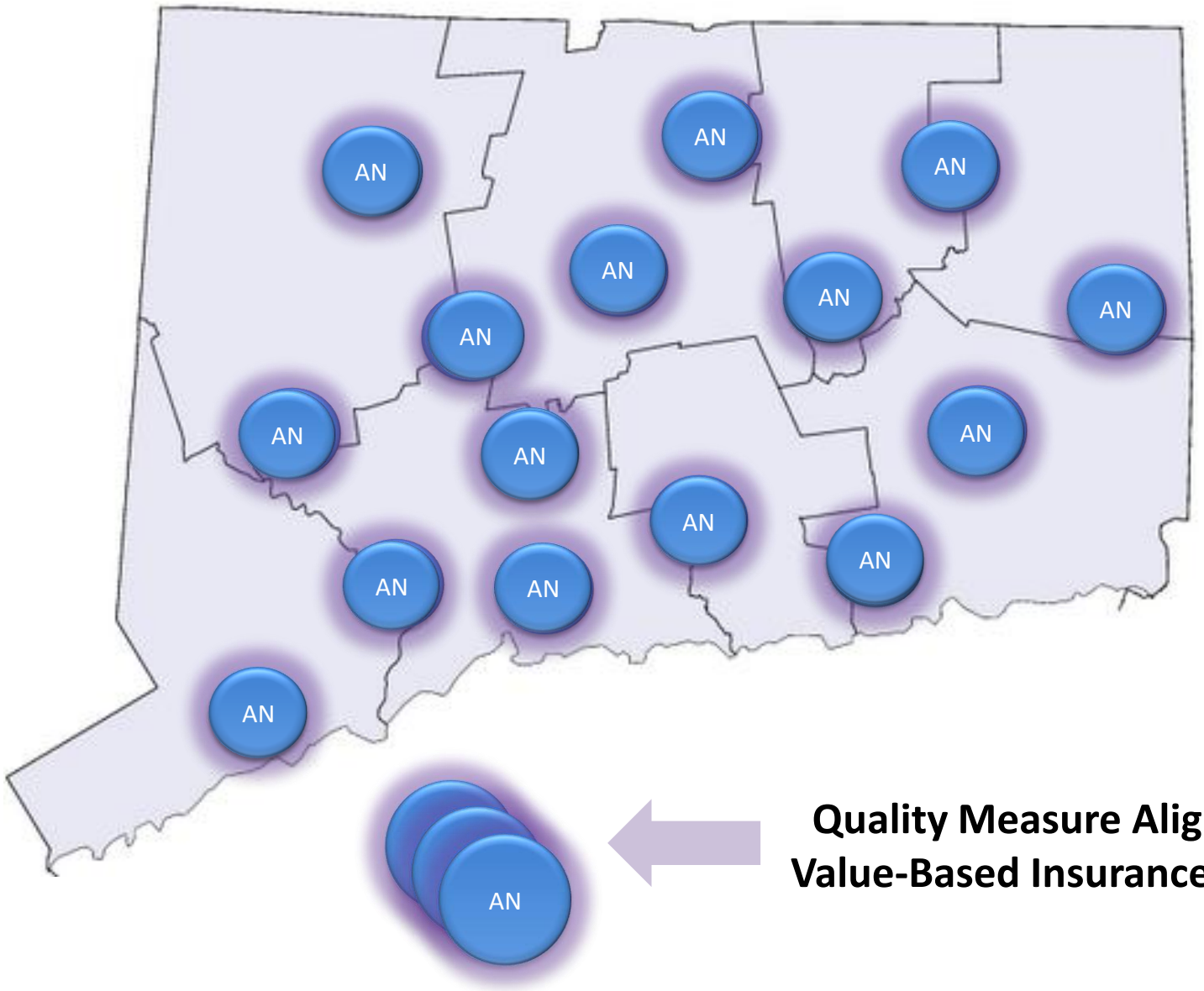
SIM Targeted Initiatives and FQHCs

- SIM targeted initiatives focus on Federally Qualified Health Centers (FQHCs), as well as ANs. Much of this narrative applies to FQHCs, except that FQHCs:
    - Will not require AMH support, because they are already recognized as PCMH (NCQA or Joint Commission) (there may be one or two exceptions)
    - May have limitations on their ability to participate in CCIP as a result of their receipt of Transforming Clinical Practices Initiative Awards
    - Do not currently have Medicare or commercial SSP arrangements; consequently, MQISSP will get them to greater than 50% of their population in VBP, based on that experience, commercial or Medicare VBP contracts would follow

Targeted Initiatives

Statewide Initiatives

Statewide Initiatives



Value-based Payment

Shared Savings Program - Participation Projections

Year	Beneficiaries	%
2016	1,305,000	38%
2017	1,745,000	50%
2018	2,270,000	64%
2019	2,596,000	73%
2020	3,117,000	88%

Estimated 2014 State Population: 3,596,677

Quality Measure Alignment

Quality Measure Alignment

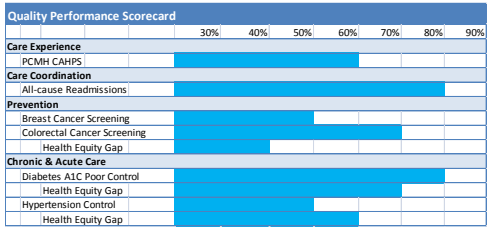
Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard

Outcomes Measures

Today:

Health Plan → *Claims Data*

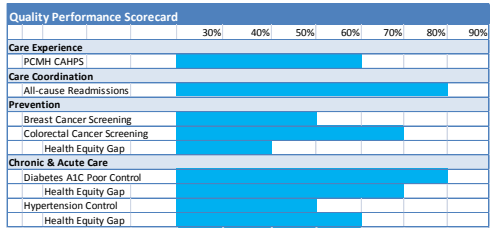


Process Measures

(E.g., Diabetes foot exam, well-care visits, medication adherence)

National consensus to move towards outcomes:

Health Plan → *Claims Data* + *EHR Data*



Process & Outcome Measures

(E.g., diabetes A1C control, blood pressure control, depression remission)

Opportunities and barriers

- Producing new measures is expensive
- Currently, all costs are borne by health plans and their clients
- SIM funds can support the conduct of care experience surveys and production of measures that will otherwise have to be produced separately by each payer

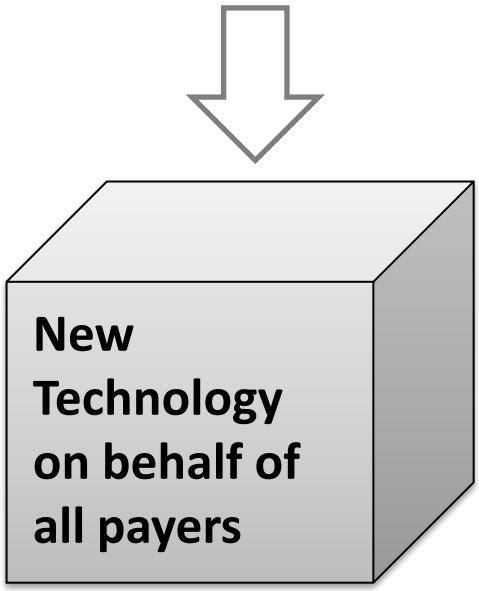
Core Measure Set

Payers currently produce claims based measure

State proposes to produce

- **EHR based measures**
- **Care experience survey measures**

SIM Funded HIT



EHR measure production

Provisional Core Quality Measure Set 10-6-15

Consumer Experience Measure	NQF	ACO
PCMH – CAHPS measure	0005	

Care coordination/patient safety	NQF	ACO
Plan all-cause readmission	1768	
All-cause unplanned admissions for patients with DM		36
Asthma in younger adults admission rate	0283	
Asthma admission rate(child)	0728	
Emergency Department Usage per 1000		
Documentation of current medications in the medical record	0419	39
Annual monitoring for persistent medications (roll-up)	2371	
Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		

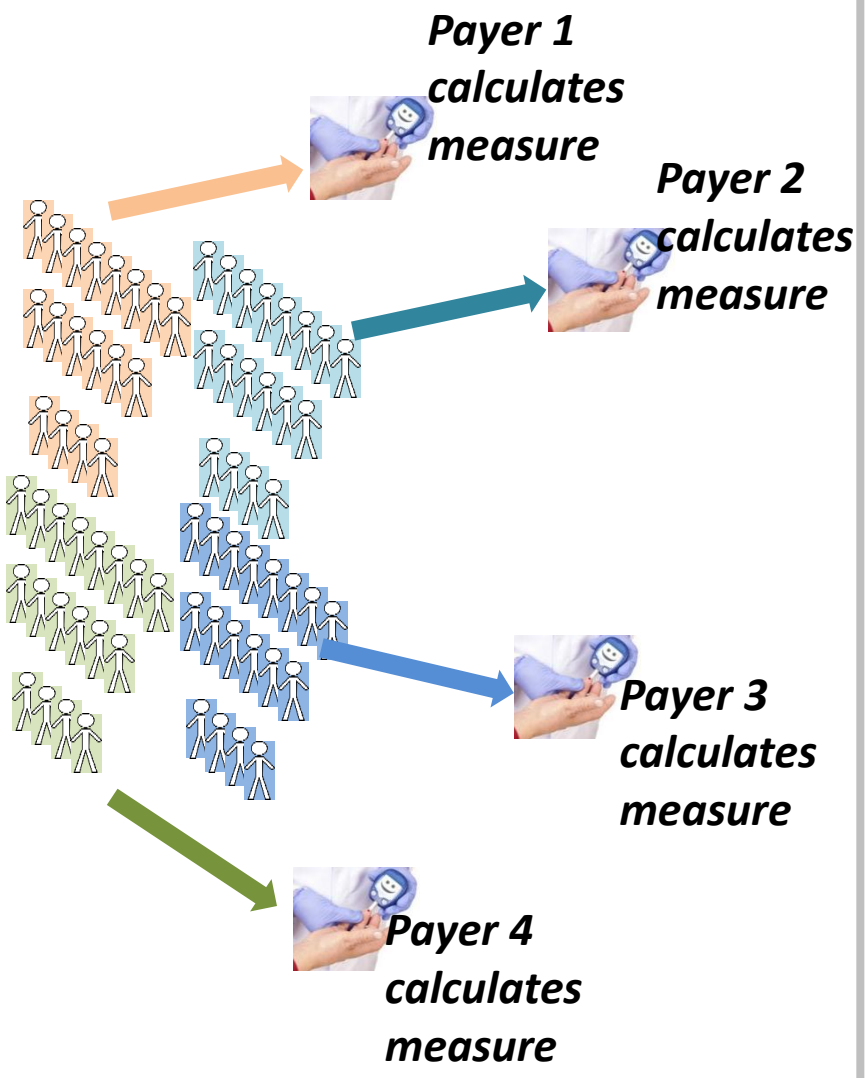
Prevention Measure	NQF	ACO
Breast cancer screening	2372	20
Cervical cancer screening	0032	
Chlamydia screening in women	0033	
Colorectal cancer screening	0034	19
Adolescent female immunizations HPV	1959	
Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024	
Preventative care and screening: BMI screening and follow up	0421	16
Developmental screening in the first three years of life	1448	
Well-child visits in the first 15 months of life	1392	
Well-child visits in the third, fourth, fifth and sixth years of life	1516	
Adolescent well-care visits		
Tobacco use screening and cessation intervention *Prenatal Care & Postpartum care*	0028 1517	17
Frequency of Ongoing Prenatal Care (FPC)	1391	
Oral health: Primary Caries Prevention	~~1419~~	
Screening for clinical depression and follow-up plan	0418	18
Oral Evaluation, Dental Services (Medicaid only)	2517	
Behavioral health screening (pediatric, Medicaid only, custom measure)		

Acute & Chronic Care Measure	NQF	ACO
Medication management for people with asthma	1799	
Asthma Medication Ratio	1800	
DM: Hemoglobin A1c Poor Control (>9%)	0059	27
DM: HbA1c Screening (interim measure until NQF 0059 is stood up)	0057	
DM: Diabetes eye exam	0055	41
DM: Diabetes foot exam	0056	
DM: Diabetes: medical attention for nephropathy	0062	
HTN: Controlling high blood pressure Use of imaging studies for low back pain	0018 0052	28
Avoidance of antibiotic treatment in adults with acute bronchitis	0058	
Appr. treatment for children with upper respiratory infection *Cardiac strss img: Testing in asymptomatic low risk patients*	0069 0672	

Behavioral Health Measure	NQF	ACO
Follow-up care for children prescribed ADHD medication	0108	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only, custom measure)		
Depression Remission at 12 Twelve Months	0710	40
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	
Unhealthy Alcohol Use – Screening		

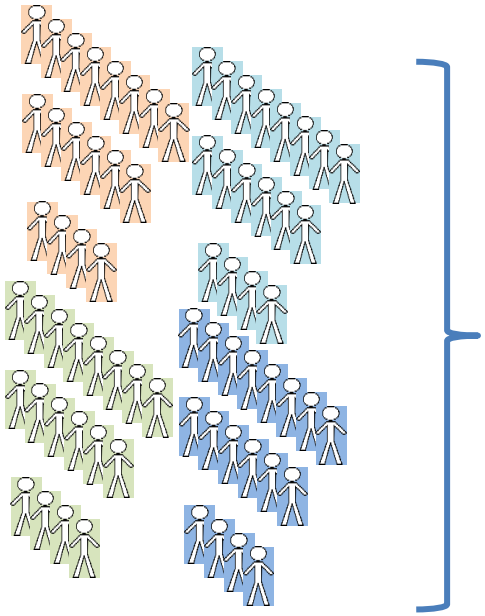
Payer Agnostic Measures

Payer specific measure:



Agnostic measure:

All patients in a shared savings arrangement



Agnostic Measure

(calculated without regard to payer)

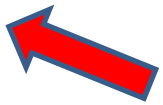
A health plan or employer would need to accept aggregate performance as a reasonable proxy for payer or employer specific sub-populations.

In other words, an employer would assume that providers will be as effective managing diabetes for their own employees, as anyone else's employees.

Quality Measure Alignment

Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard?

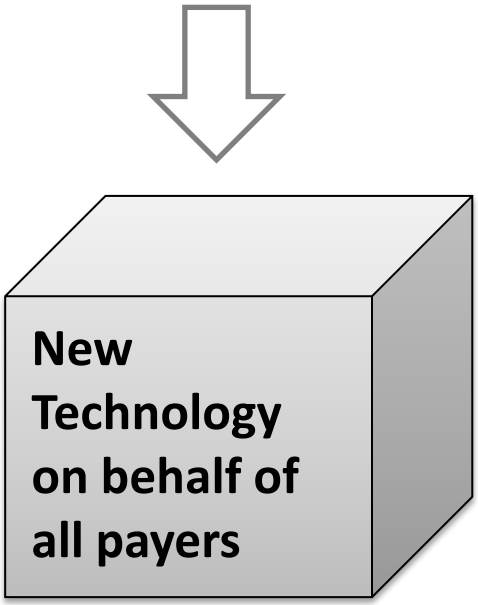


Future focus of Quality Council

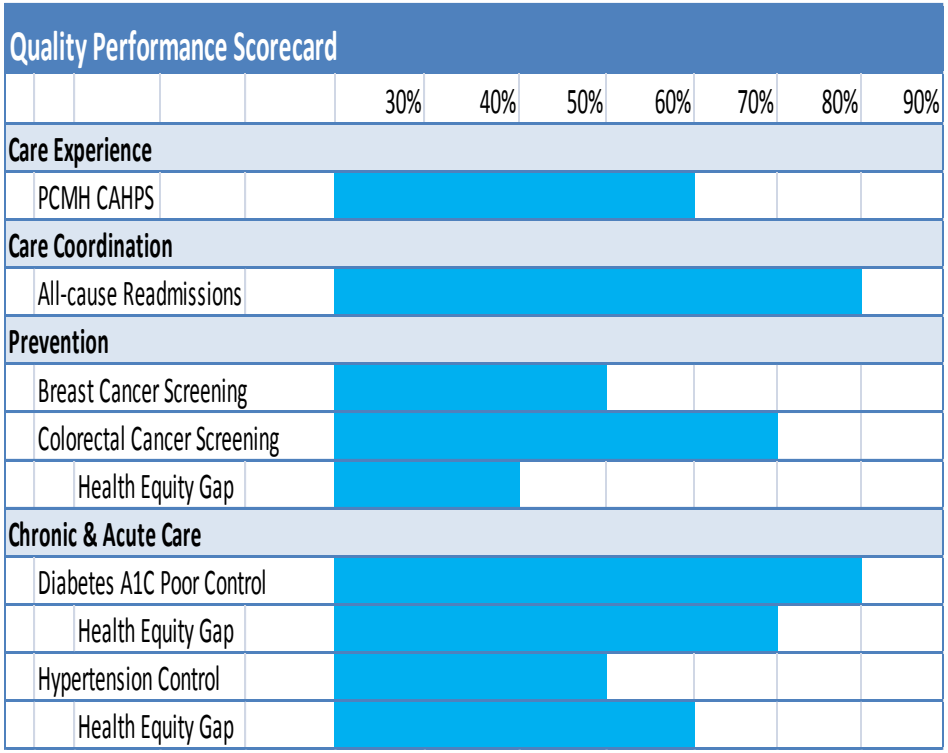
Common Scorecard?

Payer agnostic scorecard for public reporting

SIM Funded HIT?



Claims and EHR Data?



APCD?

Value-based Insurance Design

Value-based Insurance Design

...the use of plan incentives to encourage employee adoption of one or more of the following:

New and innovative approaches

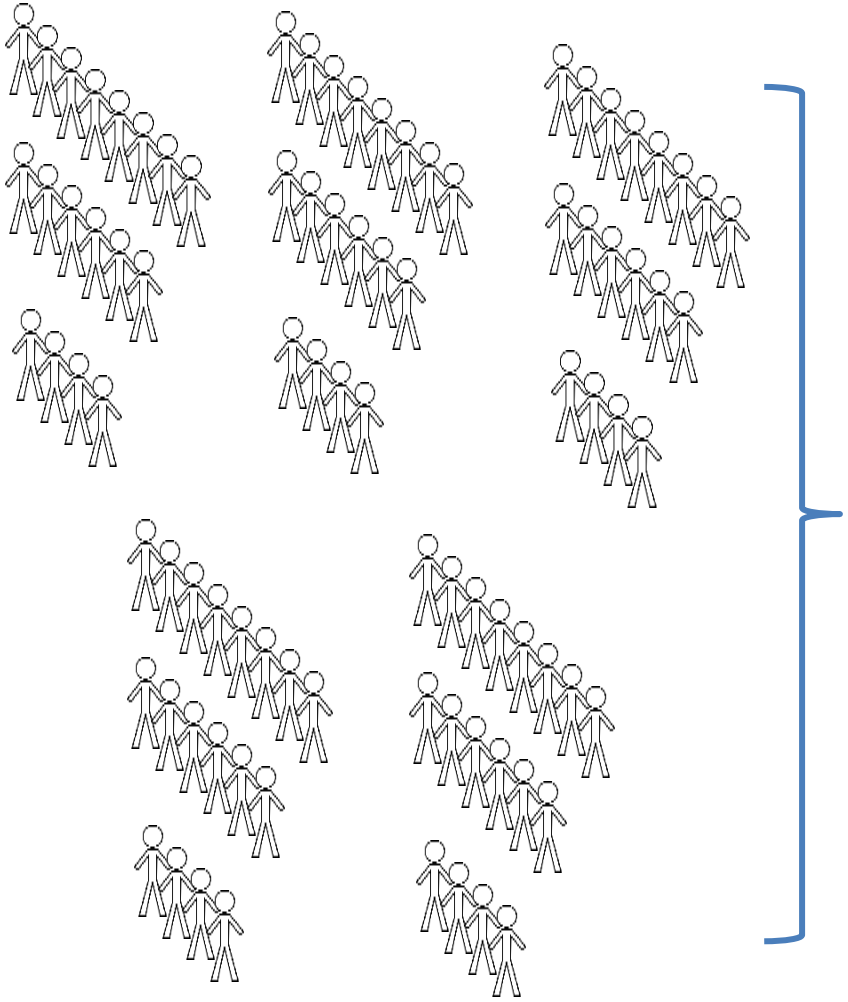
Adopt healthy lifestyles
(e.g. smoking cessation, physical activity)

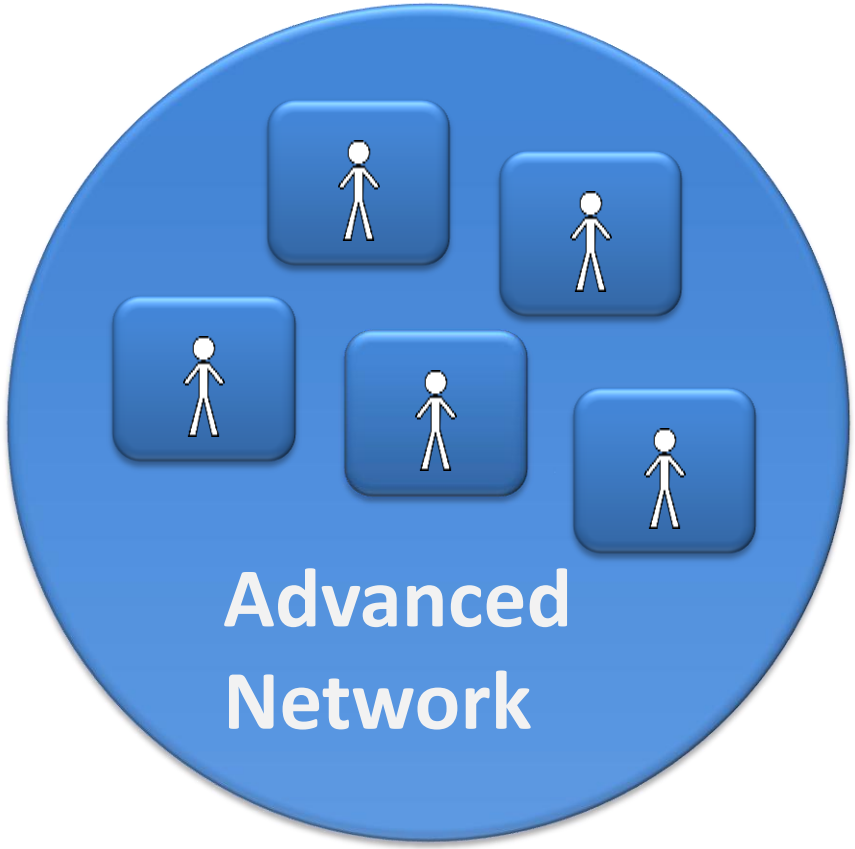
Use high value services
(e.g., preventative services, certain prescription drugs)

Use high performance providers
Who adhere to evidence-based treatment

- **Health promotion & disease management**
- **Health coaching & treatment support**

Aligning strategies to engage consumers and providers



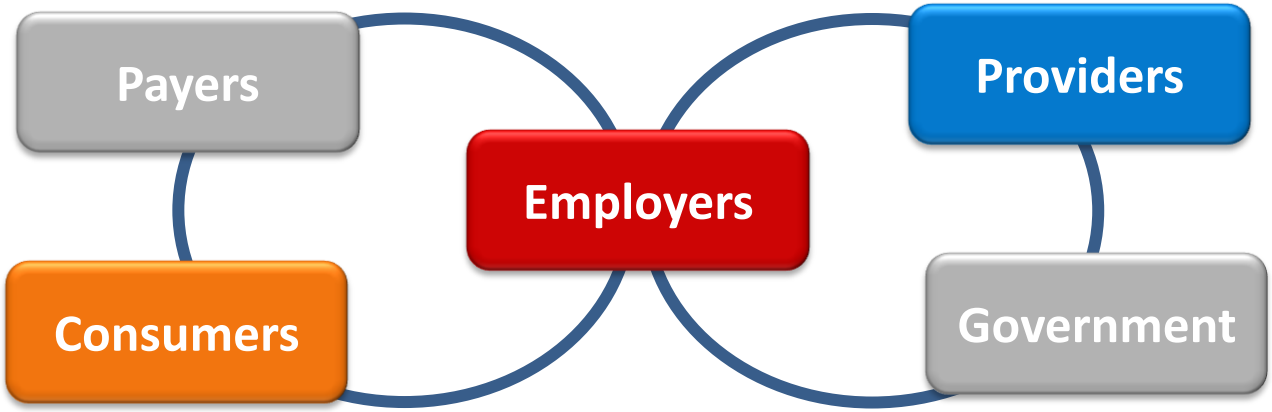


Value-based Insurance Design

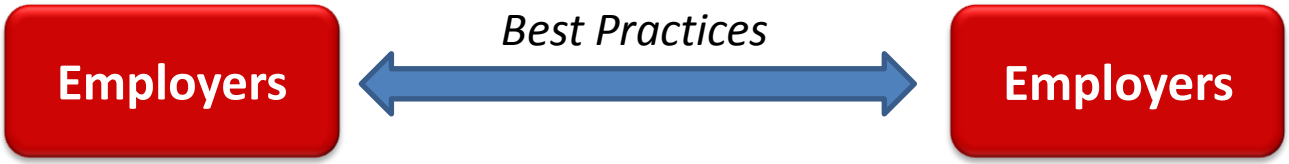
Value-based Payment

Program Goals

1. Develop prototype VBID plan designs that align the interests of consumers and providers



2. Provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans



Key Partners

CBIA
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION

NORTHEAST BUSINESS GROUP ON HEALTH

CONNECTICUT BUSINESS GROUP ON HEALTH
Promoting a better healthcare delivery system

STATE OF CONNECTICUT
QUI TRANSTULIT SUSTINET
COMPTROLLER'S OFFICE

Office of the State Comptroller (state employee health plan)

SIM VBID Components

- **Employer-led Consortium**: peer-to-peer sharing of best practices

- **Prototype VBID Designs**: using latest evidence, to make it easy for employers to implement

- **Annual Learning Collaborative**: including panel discussions with nationally recognized experts and technical assistance

access health CT
Connecticut's Health Insurance Marketplace

CT's Health Insurance Market Exchange) will implement VBID in Year 2 of the Model Test (subject to Board approval)

Value-Based Insurance Design - Accountability Metrics

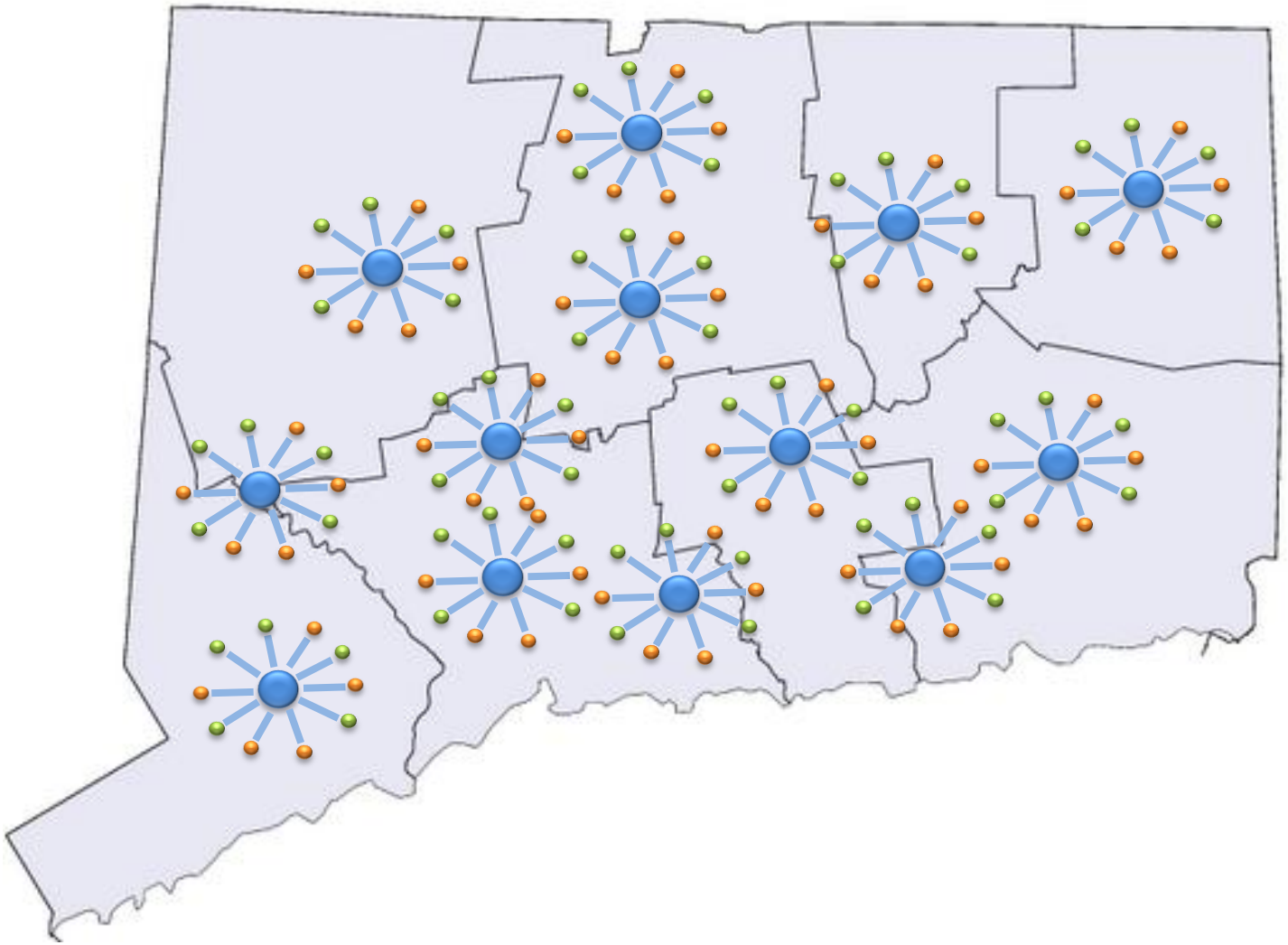
Year	Percent adoption
2016	44%*
2017	53%
2018	65%
2019	74%
2020	85%

*Estimate – will establish empirical baseline 2015

Health Enhancement Communities 3.0

Community and clinically integrated

throughout Connecticut



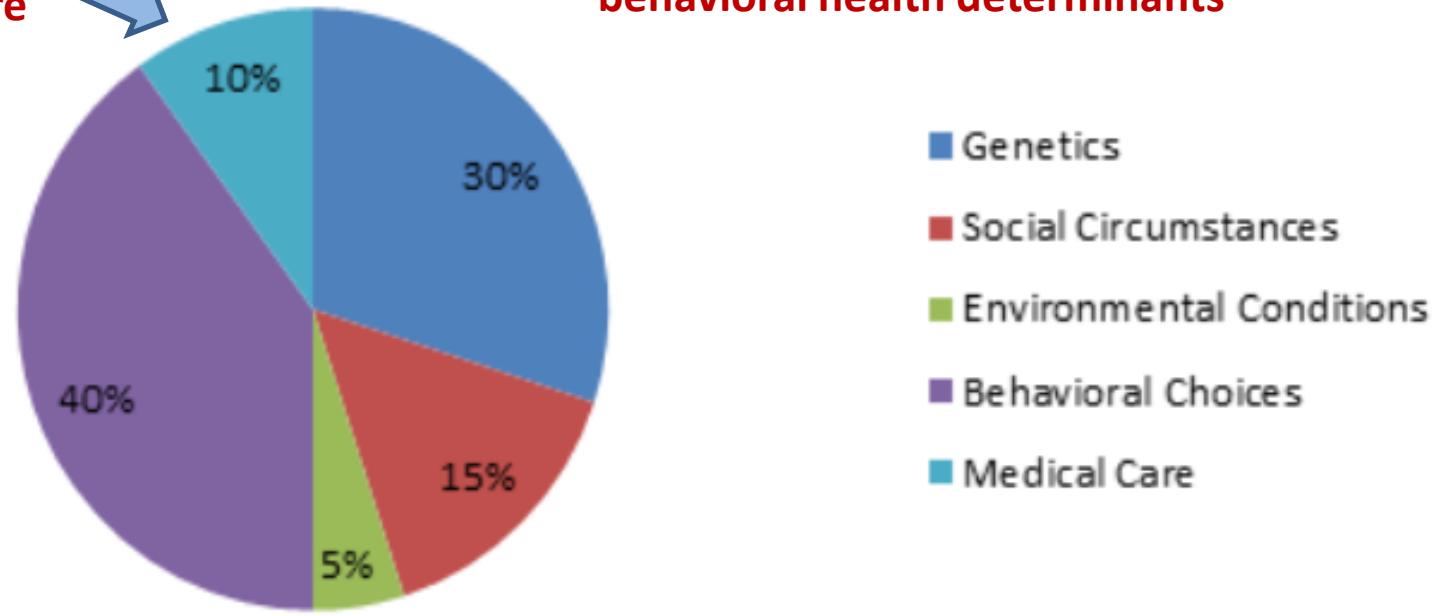
ACO accountability rewards better healthcare…

but it does not reward better health

Health determinants that affect mortality

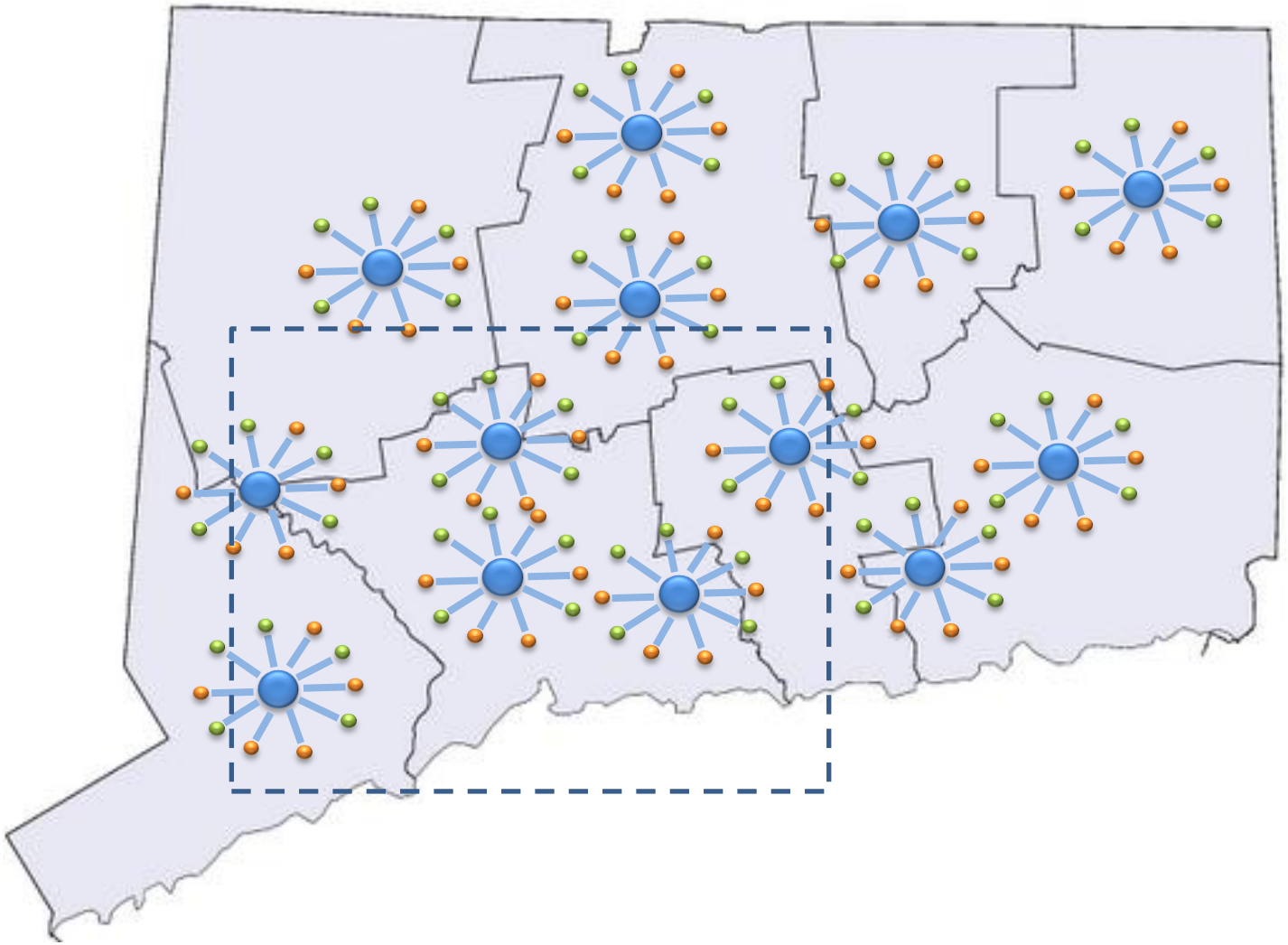
10% is healthcare

60% is social, environmental and behavioral health determinants



Taking aim at the determinants of health requires…

a regional focus

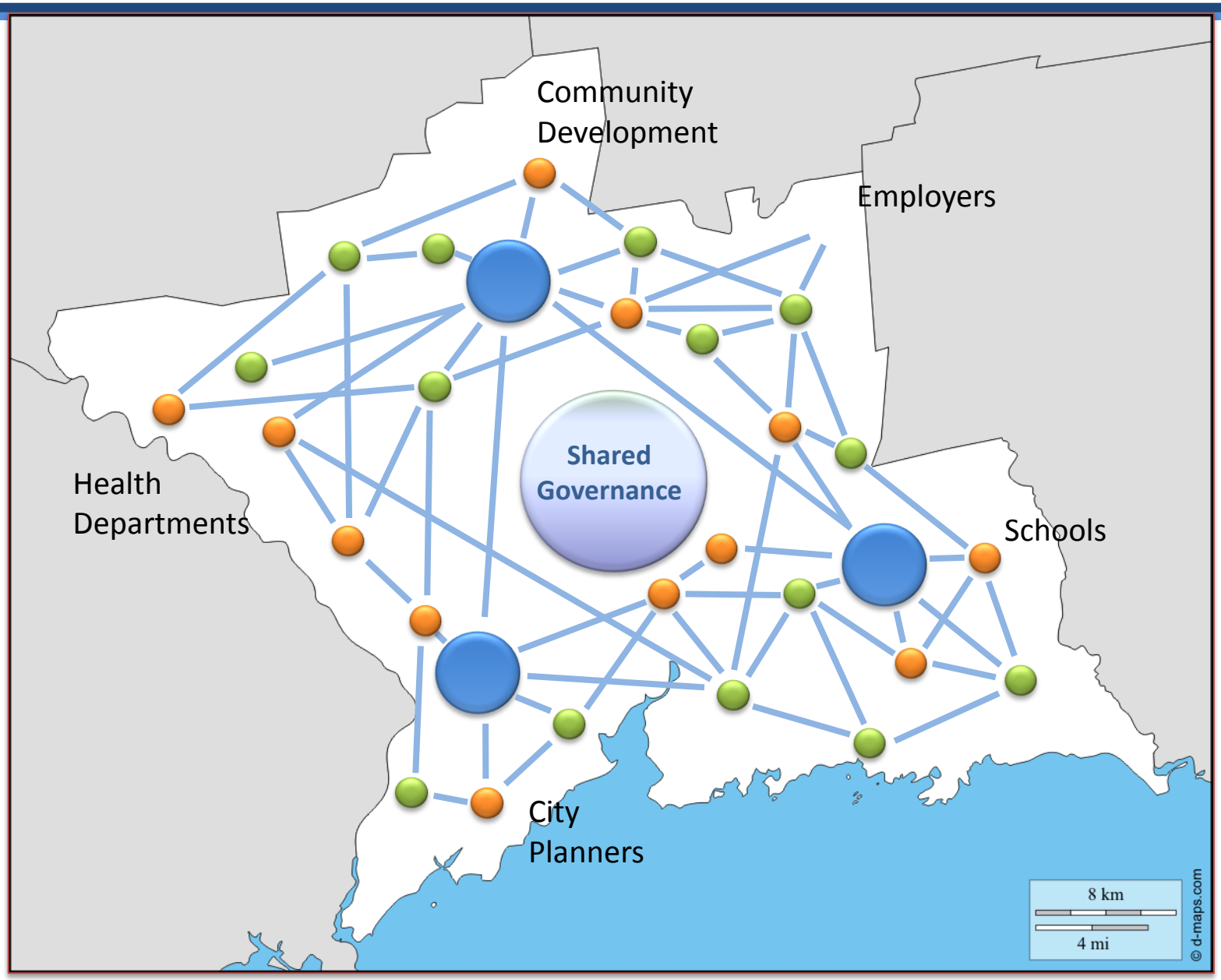


Expand linkages among community stakeholders…

building upon those that already exist

- Relationships among ACOs and all community stakeholders
- Accountability for the health and well-being of all community residents

A pathway to community accountability



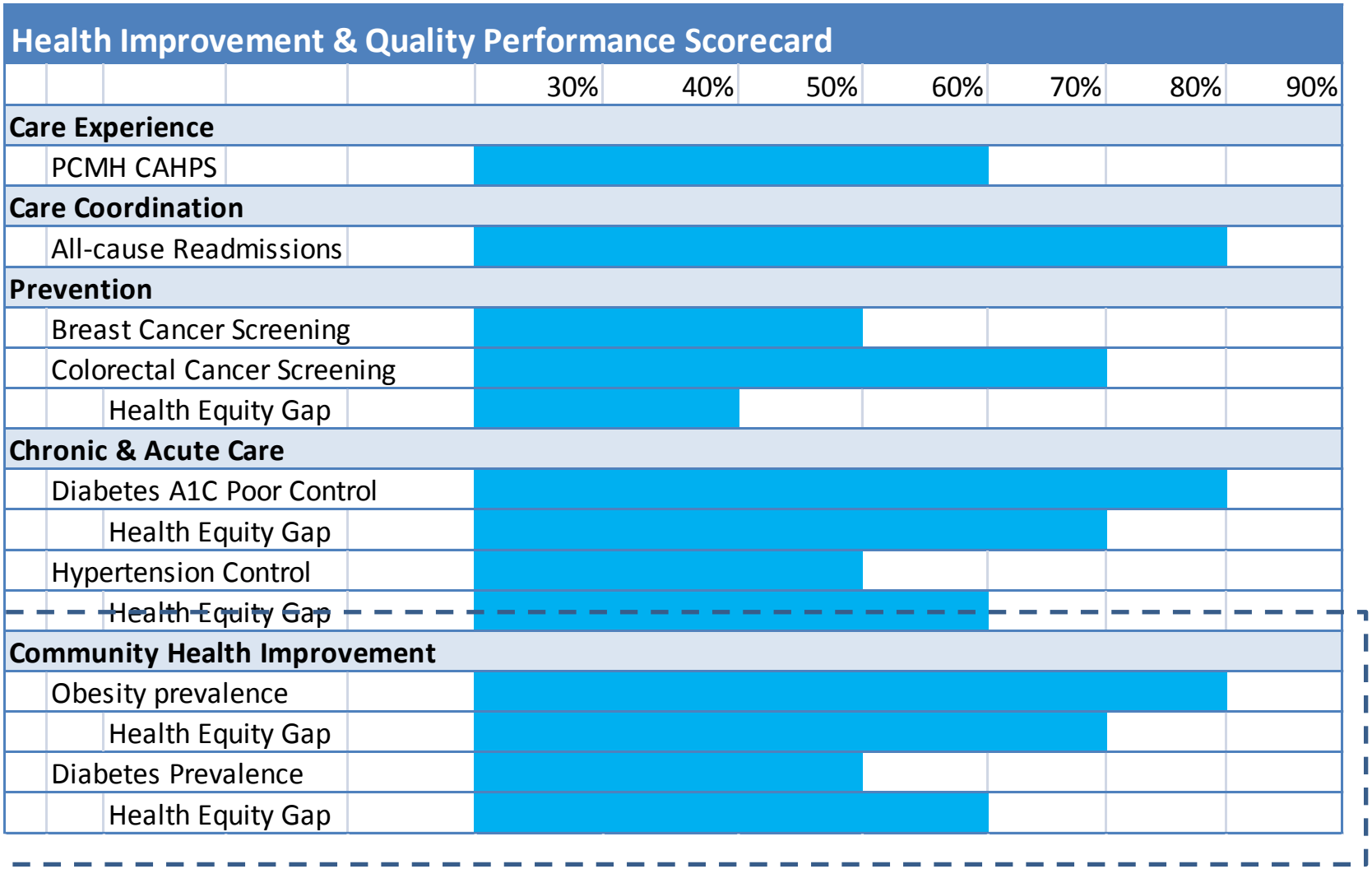
Example only: actual regions may be smaller and/or have different boundaries

Accountability for…

- All residents of the community
- Performance
  - improving community health (i.e., prevention outcomes)
  - improving health equity
  - lowering the cost of healthcare and the cost of poor health

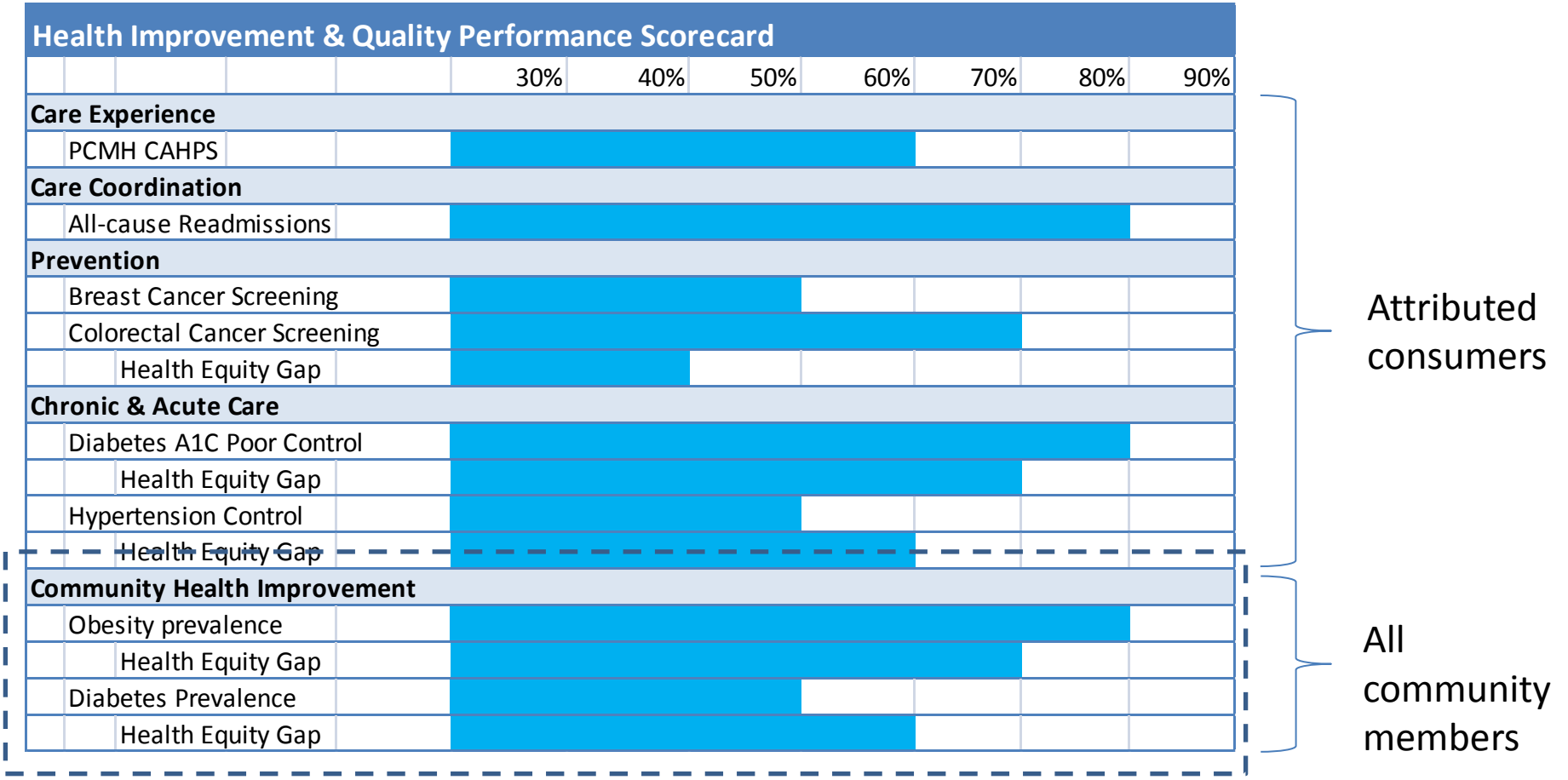
Rewards for ACOs that play a role in producing…

measurable improvement in community health



Rewards for ACOs that play a role in producing…

measurable improvement in community health



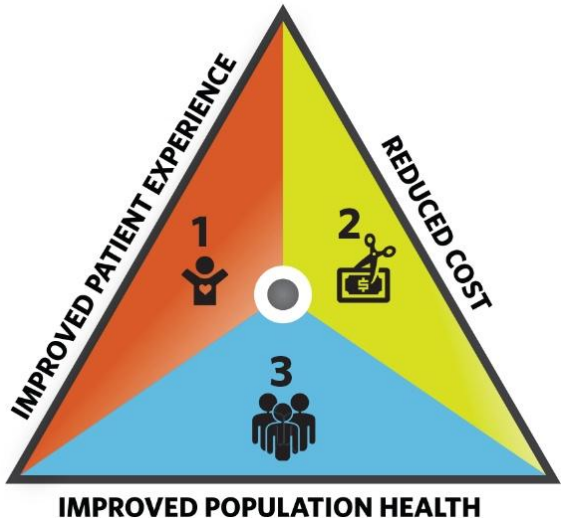
Rewards for community participants…

through new vehicles for reinvestment

- Wellness trust?
- Community stakeholder distributions?
- Consumer incentives?
- Targeted investments…for example
  - Access to healthy food
  - Enhanced walkability
  - Opportunities for an active lifestyle
  - Improvements in housing stock

Evaluation

Accountability Aims by 2020



By 6/30/2020 Connecticut will:

Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

CT SIM Test Grant: Aims

Aims:

By 6/30/2020 Connecticut will:

Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

Measure	Baseline	2020 Goal
Percent of adults who are obese	24.50%	22.95%
Percent of children who are obese	18.80%	17.65%
Percent of children in low-income households who are obese	38.00%	35.55%
Percent of adults who currently smoke	17.10%	14.40%
Percent low income adults who smoke	25.00%	22.43%
Percent of youth (high school) who currently smoke	14.00%	12.72%
Percent of adults with diabetes	8.50%	7.86%
Percent of adults with diabetes – low income	14.30%	11.32%

* Baselines & goals may change due to new data

CT SIM Test Grant: Aims

Aims:

By 6/30/2020 Connecticut will:

Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

Measure	Baseline	2020 Goal
% adults regular source of care	83.9%	93.0%
Risk- std. all condition readmissions	15.9	13.1
Ambulatory Care Sensitive Condition Admissions	1448.7	1195.1
Children well-child visits for at-risk pop	62.8	69.1
Mammogram for women >50 last 2 years	83.9	87.7
Colorectal screening- adults aged 50+	75.7	83.6
Colorectal screening- Low income	64.9	68.2
Optimal diabetes care- 2+ annual A1c tests	72.9	80.1
ED use- asthma as primary dx (per 10k)	73.0	64.0
Percent of adults with HTN taking HTN meds	60.1%	69.5%
Premature death- CVD adults (per 100k)	889.0	540.0

* Baselines & goals may change due to new data

CT SIM Test Grant: Aims

Aims:

By 6/30/2020 Connecticut will:

Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

A major goal of the Model Test is to improve equity in access and quality. We will monitor equity gaps for the core dashboard measures and target selected areas for improvement.

CT SIM Test Grant: Aims

Aims:

By 6/30/2020 Connecticut will:

Improve Population Health

Reduce statewide rates of diabetes, obesity, tobacco use, and asthma

Improve Health Care Outcomes

Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets

Reduce Health Disparities

Close the gap between the highest and lowest achieving populations for key quality measures impacted by health inequities

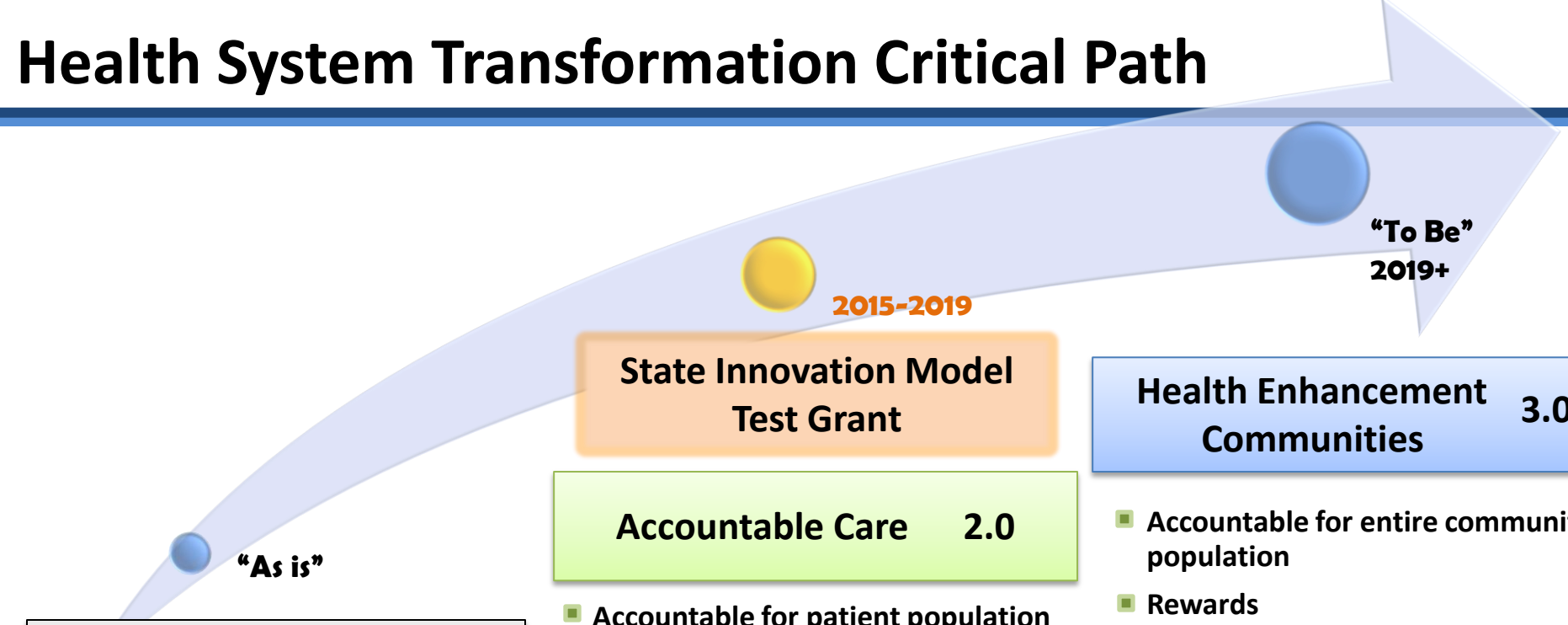
Reduce Healthcare Costs

Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

Measure	Baseline	2020 Goal
ASO/Fully insured	$457	$603
State employees w/o Medicare	$547	$722
Medicare	$850	$1,096
Medicaid/CHIP, incl. expansion*	$390	$509
Average	$515	$679

* Baselines & goals may change due to new data

Health System Transformation Critical Path



"As is"

Fee for Service 1.0

- Volume-based
- Poorly coordinated
- No quality & cost transparency
- Unsustainable healthcare costs
- Limited data infrastructure
- Persistent health disparities
- Uninformed consumers

2015-2019

State Innovation Model Test Grant

Accountable Care 2.0

- Accountable for patient population
- Rewards
  - Better health outcomes
  - Preventive care processes
  - Lower cost of healthcare
- Competition on healthcare outcomes, experience & cost
- Coordination of care across medical neighborhood
- Community integration to address social-demographic factors that affect outcomes

"To Be"
2019+

Health Enhancement Communities 3.0

- Accountable for entire community population
- Rewards
  - Prevention outcomes
  - Lower cost of healthcare & health
- Cooperation to reduce risk and improve health
- Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities
- Community initiatives to address social-demographic factors that affect health

Questions

Appendix: Core Intervention Standards

7. Core Standards

The three core interventions focus on populations who have demonstrated health needs that align with SIM goals, align with CT population health goals, and that provide both evidence-based standards for improvement with flexibility in implementation. Their objectives are as follows:

Individuals with complex health needs

- Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status

Individuals experiencing health equity gaps

- Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this program is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care

Individuals with unmet behavioral health needs

- Intended to improve the ability of primary care practices to identify and treat behavioral health needs within the primary care setting, to ensure referral and linkage for those who require behavioral health specialty care, and follow-up

Design Programs: Complex Individuals

Complex Patient Intervention Objective

Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status.

Intervention Highlights

- Complex individuals will be **identified** through risk stratification that considers **clinical**, **behavioral**, and **social** risk factors
- Individuals with complex needs will be connected to a **Comprehensive Care Team (CCT)** to receive more intensive care management support
- The CCT will include a **Community Health Worker** to provide community focused care **coordination with social services** and to provide **culturally and linguistically aligned self-care management education**. Additionally there will be a **case manager**, a **clinically focused care coordinator,** and a **CCT manager**
- The CCT will also have access to a **licensed behavioral health specialist** to address behavioral health needs of complex individuals

Design Programs: Complex Individuals

Intervention Highlights

- The network will conduct a **root cause analysis** among their complex patient population to identify and implement additional interventions to the CCT and/or additional CCT team members that may be beneficial
- The CCT will perform a **person-centered needs assessment** that will inform a **person-centered care coordination plan** to support the individual to reach his/her clinical, social, and behavioral treatment goals. This plan will be incorporated into the primary care plan and coordinated through the primary care providers and expanded community care team.
- The individual will be **transitioned to self-directed care management** when the CCT and individual feels ready
- There will be processes in place to **monitor transitioned patients** for the need to reconnect post-transition

Design Programs: Equity Gaps

Equity Gap Intervention Objective

Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this programs is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care.

Intervention Highlights

- The CCIP equity gap program will include two elements – 1) standards on how to do **health equity continuous quality improvement**; and 2) standards for an **intervention to address identified equity gaps**
- The **continuous quality improvement** standards provide guidance on how to routinely capture and analyze data to **identify health care disparities at a population level**
- The intervention standards provide guidance on how to **standardize certain care processes to make them more culturally and linguistically appropriate** and offering the **support of a Community Health Worker to those who will benefit** from more culturally supportive care

Design Programs: Equity Gaps

Intervention Highlights

- The CHW will be trained to offer culturally and linguistically appropriate **education specific to the patient's clinical area of need** (e.g.; diabetes) and on **better self-care management skills**.
- The CHW will collaborate with the patient to **develop a person-centered self-care management plan** that reflects the patients cultural needs, personal preferences, values, strengths and **readiness to change.**
- The networks will monitor the equity gap intervention for **effectiveness** through monitoring **quality** and **patient experience** metric

Design Programs: Behavioral Health Integration

Behavioral Health Integration Intervention Objective

The Behavioral Health Integration standards are intended to improve the ability of primary care practices to identify and treat behavioral health needs either within the primary care setting or to make, confirm, and close the communication loop on a referral when necessary

Intervention Highlights

- The networks will incorporate the use of a **screening tool** to screen all patients for **mental health, substance abuse, and trauma needs**
- When a behavioral health **need is identified** the primary care providers will determine in collaboration with the patient if they want/can be treated in the primary care setting or would prefer/need a referral
- Networks will **develop an MOU with at least one behavioral health provider** to support the facilitation and accountability for the referral process
- Processes and protocols will be developed in partnership with behavioral health providers to facilitate **referral tracking, follow up, and ensuring that the behavioral health care plan is shared with primary care** when a referral is made
- Provision of appropriate **behavioral health training** on **promotion**, **detection**, **diagnosis**, and **referral for treatment** for primary care practice

Appendix: Elective Intervention Standards

7. Elective Standards

The elective standards represent best practices in areas that complement the core standards, but that are not limited to patients within the focus populations of CCIP. The objectives of each intervention are as follows:

Comprehensive Medication Management

- Intended to assure safe and appropriate medication use by engaging patients, caregivers/family members, and health care providers improve health outcomes related to the use of medications.

Electronic Consults

- Intended to improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. E-consults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.

Oral Health

- Improve dental and overall health for all populations by providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is a an oral/systemic link. An individual's oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.

Design Programs: Oral Health Integration

Oral Health Integration Intervention Objective

Improve dental and overall health for all populations through providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is a an oral/systemic link. An individual's oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.

Intervention Highlights

- The networks standardize care processes to **routinely do an oral health screening and exam**
- The appropriate primary care providers are trained to **provide preventive care** within the primary care setting
- The practice will develop resources and processes/protocols **to make**, **manage**, and **close out dental referrals** with a **preferred dental network** for individuals who do not have a regular source of dental care
- The network and the preferred dental network establish **technology to support communication** of the relevant care information between primary care and dental providers

Design Programs: E-consults

E-consults Intervention Objectives:

Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. E-consults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.

Intervention Highlights

- The networks will **elect one specialty area to do e-consults** – common areas already in practice in Connecticut include cardiology and dermatology
- **A specialist practice/providers will be identified** either within or outside the network, depending on the Advanced Network/FQHCs physician make up, with which to **establish e-consult protocols**
- The designated specialists reviewing e-consults will determine 1) if **a face to face is needed**; 2) if **more information on the patient is needed** before a determination about a face to face consult can be made; or, 3) A **face to face consult is not needed** and a **consult note is provided** from the specialist to the primary care provider on how to care for the patient in the primary care setting
- The networks will have to establish a **reimbursement mechanism** for e-consults

Design Programs: Comprehensive Medication Management

Medication Therapy Management Objective

CMM is a system-level, person-centered process of care provided by pharmacists to optimize the complete drug therapy regimen for a patient's given medical and socio-economic condition. This intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. This intervention is designed assure safe and appropriate medication use by engaging patients, caregivers/family members, and health care providers improve health outcomes related to the use of medications.

Intervention Highlights

- The networks develop processes to **assess the risk of a patient's pharmacy regimen**.
- The networks **design a pharmacist integration model** that aligns with their needs and capacity
- The pharmacist **integrates with the care team** and provides CMM services
- The **medication action plan is person-centered** and addresses medical issues such as appropriateness, efficacy, and safety as well as socio-economic issues such as affordability, cultural traditions and lifestyle
- CMM is a fluid process that **includes follow-up and subsequent touch points** with the patient
- The medication **action plans becomes part of the primary care plan** and becomes part of the care conferences regarding patient progress

Appendix: Community Health Collaboratives

7. Community Health Collaboratives

Establish consensus protocols to better standardize the linkage to and provision of socio-economic services related to the health needs of patients and care transition coordination among community participants. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next stage of shared accountability under population health related SIM initiatives. The community consensus guidelines will impact patients with complex conditions and health equity gaps, who are disproportionately in need of better coordination with community resources.

Design Programs: Community Consensus & Linkages

Shared Governance Objective

Development of Advanced Network and FQHC linkages to community resources is a key component of the CCIP. Because many of the needed community resource providers are resource, capacity, and geographically constrained the PTTF is recommending convening community stakeholders to establish local Community Health Collaboratives to better integrate social services. The structure will be developed by the technical assistance vendor in the service areas where there are Advanced Networks and/or FQHCs participating in CCIP with the involvement of the CCIP participants and other key healthcare stakeholders to be transitioned to local oversight. Efforts are already underway to coordinate these activities with DPH and other public health efforts.

Intervention Highlights

- The **Community Health Collaboratives** will be the primary vehicle of community consensus.
- To establish the Community Health Collaboartives the technical assistance vendor will convene healthcare stakeholders from **across the healthcare continuum** and **relevant community stakeholders**
- The stakeholders convened will be representative of the community being served and has to include **consumer representation**
- The community collaborative will be responsible for establishing protocols and processes for **network linkages to shared resources in the community** and can serve as a resource for determining additional community needs (e.g.; transitions from hospitals to home)
- **Prioritization of the linkages** established will be informed by an **assessment of the communities needs and resources conducted by the community collaborative**